HOME SAFETY Review

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VOL. 14, NO. 4 - APRIL 1957

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—National Safety Council

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The Home Safety Conference is the meeting point for representatives of national organizations conducting programs that include prevention of accidents in the home. It officially represents National Safety Council home safety service subscriber-members. Conference officers (with the exception of the staff secretary) serve voluntarily without pay as the council's safety officers and planning board for home safety program.

National Safety Council
Chartered by the Congress of the United States

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HOME SAFETY REVIEW

A Magazine for Home Safety Program Leaders

VOL. 14 **NO. 4**

APRIL 1957

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Home Safety Inventory Committee

THE PRESENT INVENTORY Committee of the Home Safety Conference was appointed by John C. Thornton, chairman of the conference. Committee members (see below) are appointed for two years; half the committee changes each year.

On February 14, 1957, the Inventory Committee met in Chicago, Ill., and formally approved the format being recommended to state and local centers for the publication of their reports and for the verbal presentation of reports to interested states and communities. The appointment of state level committees for program planning and development was recommended as a logical method of utilizing information secured through the Inventory.

Comments and suggestions for the committee should be sent to: A. F. Schaplowsky, chairman, Inventory Committee of Home Safety Conference, Division of Health Education Services, c/o Kansas State Board of Health, Ground Floor, East, Masonic Temple, Topeka, Kans.

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Add convenience and safety to DRIVEWAYS

Reprinted from
***Better Homes & Gardens* magazine.**

THE RIBBONS of gravel and concrete that we call driveways are dominating features of the home landscape.* Because of their permanence, we too often accept them as they are and learn to live with their faults and limitations.

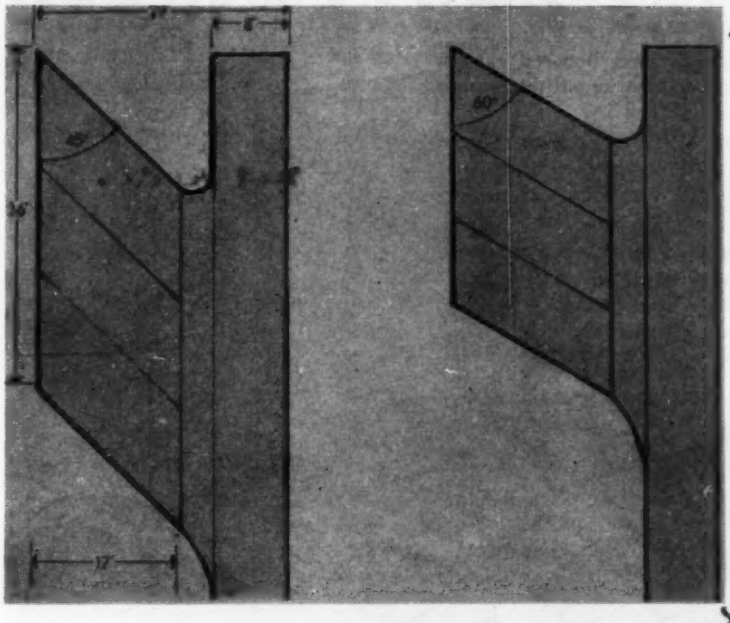
Yet, there are many ways we can increase their convenience and safety—by planting with visibility in mind, by providing landing space, and by adding turn courts, for example. Give your driveway a systematic check, and you'll soon find out if it is as up to date as your car. Then [see below] to find the appropriate how-to if you need to modernize your drive and turnaround.

Answers to these questions will help you evaluate driveway

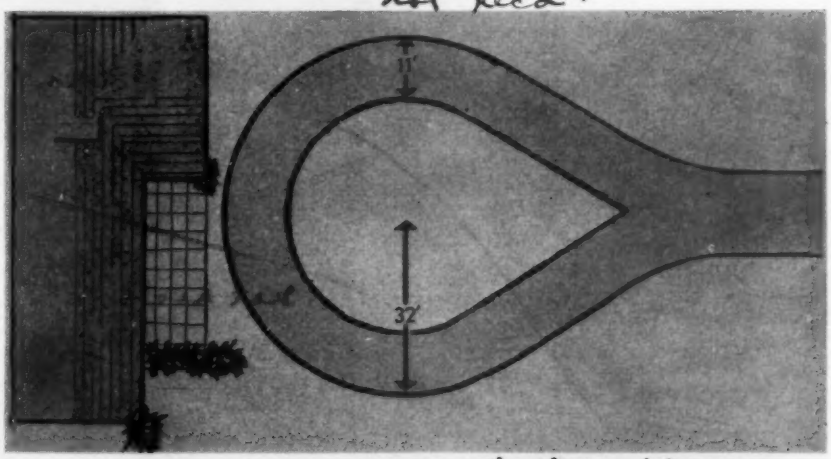
- Is your drive at least 8 feet wide? If not, some delivery trucks will have trouble negotiating it.
- Do low-hanging tree limbs brush against the top of the car after a rain or block your vision of the street, when you drive out?
- Is your driveway level where you back and turn?
- Is your driveway far enough from the house to allow you to add a landing area or pass court? In most cases, you'll need 8 feet between drive and house to get these extras.
- Do you need a turn court? You may, if you must back out under these conditions: more than 50 feet, around a curve, or into a major thoroughfare.
- Is driveway level 10 feet in front of garage?

Greatest source of danger is where driveway joins the street. Safety depends on a clear view of street as well as on a careful driver. Now that cars are being built lower, it is increasingly important to keep plantings low near the street. No hedges, solid fences, or other continuous features that block the view should be placed in either zone—the danger is too great. Drive should meet the street at an angle as close to 90 degrees as possible

Use space to side of drive for extra parking



Off-street parking is highly desirable if you entertain often or live on a busy street. Best place to get extra parking is off the turnaround area. If this is impossible, try solutions that are shown here. Both of these patterns give each car a little over 8 feet of space, so doors can open freely. If your drive is more than 8 feet wide, you can reduce the ribbon for maneuvering accordingly. Use edgings or wheel guards to prevent damage to the lawn

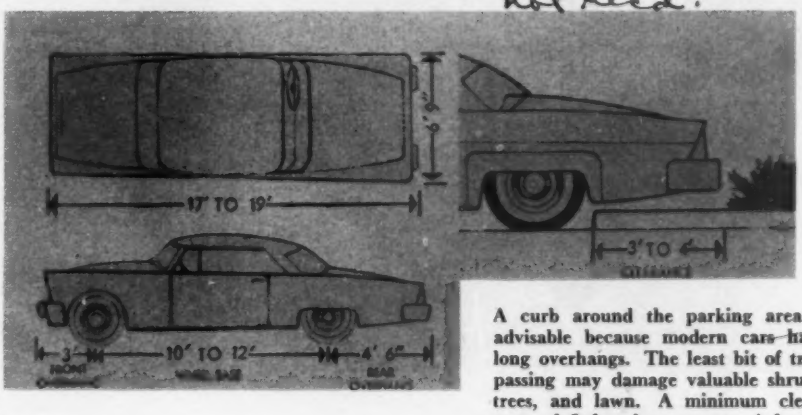


Circular turnarounds are pleasant to use and good to look at. But they take a lot of space. Don't consider them unless you can take at least 60 feet out of your lot. The minimum width for a curved drive is 11 feet, compared to an 8-foot minimum for a straight one

Plan your driveway for tomorrow's car

When you plan a driveway or parking area, you should provide space for the largest car which is likely to use the facilities. This means cars your guests will use, as well as your next car and the one after that. Driveways, like highways, outlive the cars they are designed to serve.

The dimensions of the theoretical car shown here are a composite of current models. The diagrams for parking areas and turn courts are based on the limitations of this theoretical car. The turning arcs and clearances are great enough to provide easy driving for any cars now being built, and for most delivery vehicles.



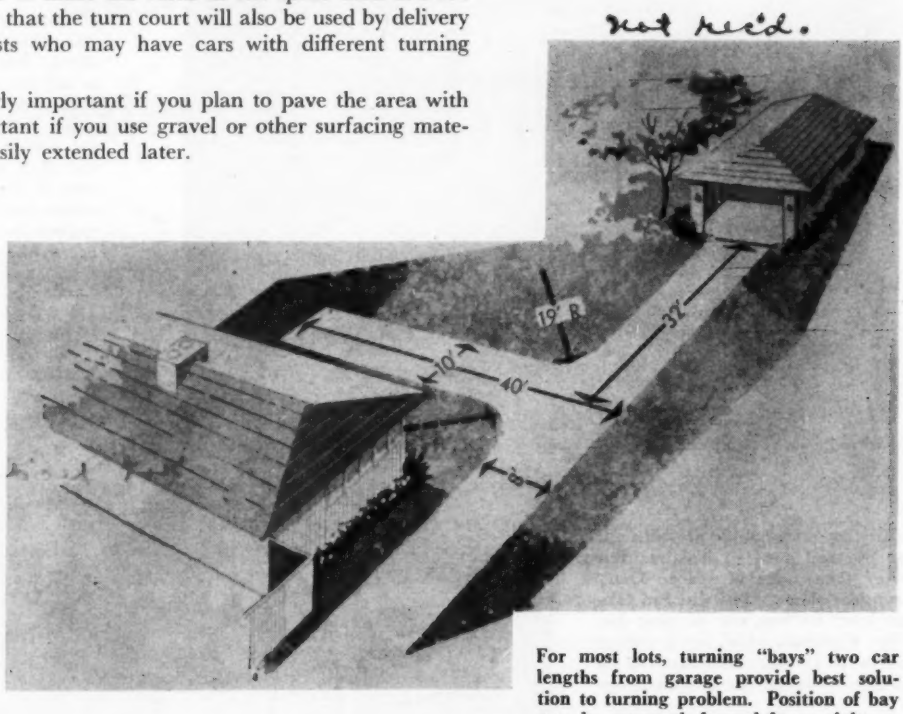
A curb around the parking area is advisable because modern cars have long overhangs. The least bit of trespassing may damage valuable shrubs, trees, and lawn. A minimum clearance of 3 feet is necessary, 4 feet is better

Turnarounds—how much space do you need for turning?

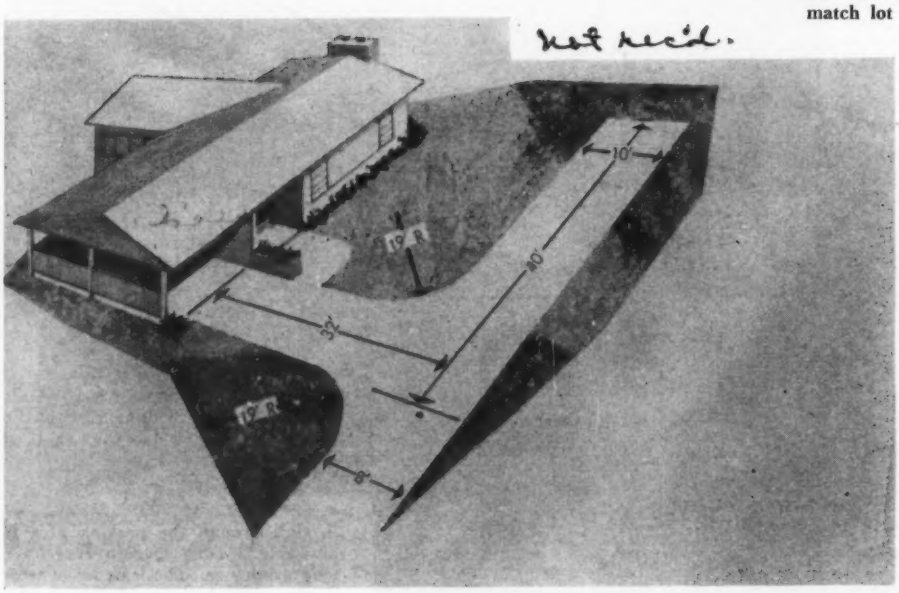
To plan a turn court, first measure distances between garage, house, and lot lines. After planning on paper, stake out the pattern and try it in the car.

You may be able to make the turns in less space than allowed here, but remember that the turn court will also be used by delivery trucks and by guests who may have cars with different turning limitations.

This is particularly important if you plan to pave the area with concrete, less important if you use gravel or other surfacing material that can be easily extended later.



For most lots, turning "bays" two car lengths from garage provide best solution to turning problem. Position of bay can be reversed from left to right to match lot



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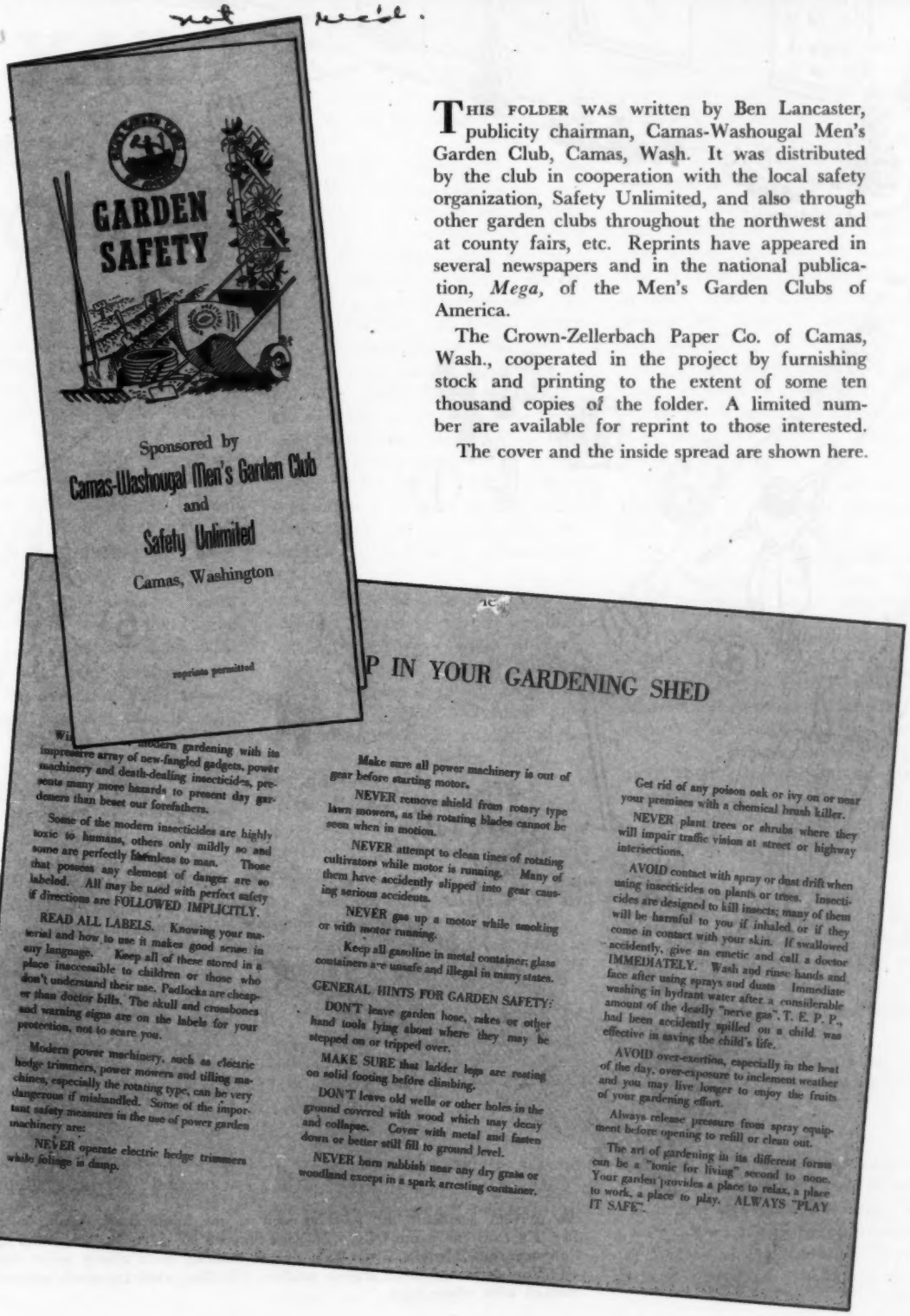
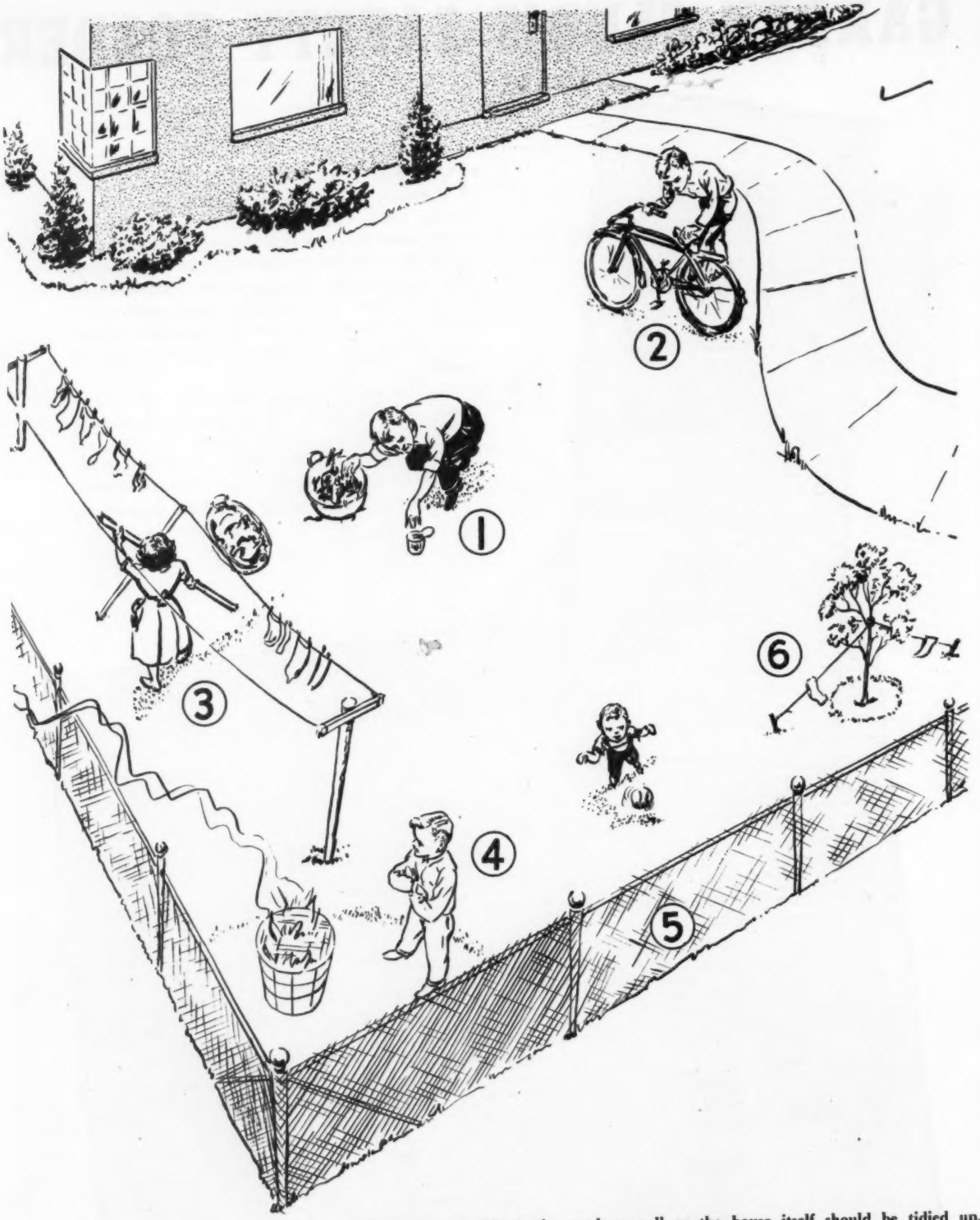
GARDEN CLUB'S SAFETY FOLDER


GARDEN SAFETY
Sponsored by
Camas-Washougal Men's Garden Club
and
Safety Unlimited
Camas, Washington
reprints permitted
P IN YOUR GARDENING SHED
Make sure all power machinery is out of gear before starting motor.
NEVER remove shield from rotary type lawn mowers, as the rotating blades cannot be seen when in motion.
NEVER attempt to clean tines of rotating cultivators while motor is running. Many of them have accidently slipped into gear causing serious accidents.
NEVER gas up a motor while smoking or with motor running.
Keep all gasoline in metal container; glass containers are unsafe and illegal in many states.
GENERAL HINTS FOR GARDEN SAFETY:
DON'T leave garden hose, rakes or other hand tools lying about where they may be stepped on or tripped over.
MAKE SURE that ladder legs are resting on solid footing before climbing.
DON'T leave old wells or other holes in the ground covered with wood which may decay and collapse. Cover with metal and fasten down or better still fill to ground level.
NEVER burn rubbish near any dry grass or woodland except in a spark arresting container.
Get rid of any poison oak or ivy on or near your premises with a chemical brush killer.
NEVER plant trees or shrubs where they will impair traffic vision at street or highway intersections.
AVOID contact with spray or dust drift when using insecticides on plants or trees. Insecticides are designed to kill insects; many of them will be harmful to you if inhaled, or if they come in contact with your skin. If swallowed accidently, give an emetic and call a doctor IMMEDIATELY. Wash and rinse hands and face after using sprays and dusts. Immediate washing in hydrant water after a considerable amount of the deadly "nerve gas", T. E. P. P., had been accidently spilled on a child was effective in saving the child's life.
AVOID over-exertion, especially in the heat of the day, over-exposure to inclement weather and you may live longer to enjoy the fruits of your gardening effort.
Always release pressure from spray equipment before opening to refill or clean out.
The art of gardening in its different forms can be a "tonic for living" second to none. Your garden provides a place to relax, a place to work, a place to play. ALWAYS "PLAY IT SAFE".

THIS FOLDER WAS written by Ben Lancaster, publicity chairman, Camas-Washougal Men's Garden Club, Camas, Wash. It was distributed by the club in cooperation with the local safety organization, Safety Unlimited, and also through other garden clubs throughout the northwest and at county fairs, etc. Reprints have appeared in several newspapers and in the national publication, *Mega*, of the Men's Garden Clubs of America.

The Crown-Zellerbach Paper Co. of Camas, Wash., cooperated in the project by furnishing stock and printing to the extent of some ten thousand copies of the folder. A limited number are available for reprint to those interested.

The cover and the inside spread are shown here.



To prevent accidents the yard as well as the house itself should be tidied up. (1) Tin cans can cause falls. (2) Park bicycles off sidewalk. (3) Prop up clothesline over head height. (4) This fire is burning in a closed mesh wire basket. (5) Yard is fenced in to protect toddler. (6) Guy wires for newly planted tree are marked with white rags.

The YARD and the PORCH

YARDS AND porches combined ranked first in both the Harrison and Marshall County Surveys as the place where accidents took place most frequently. These two places combined accounted for over half of the total number recorded.

Falls were the most important kind of accident—half of the accidents were falls. Cuts and pierces were the next most common.

Suggestions for Making the Yard Safer

1. Stumps, uneven places, holes, and protruding rocks should be eliminated, as they can cause falls.

2. Nails, old lumber, glass, wire, and tin cans can cause falls, as well as cuts and puncture wounds, and should be picked up.

3. Bikes, roller skates, and other toys should *not* be left lying around where people can stumble over them.

4. Lawn mowers and garden tools can cause permanent crippling injuries. Young children should be kept away from such implements and older children taught proper use. When a lawn mower is run over sticks and stones, these can fly and cause serious bruises or other injuries.

5. The clothesline should be high enough for an adult to walk *under* it. It should be out of the usual lane of traffic.

6. Guy wires for newly planted trees should be plainly marked—white rags will do.

7. Heavy bird baths or statuary should be well anchored in the ground to avoid danger of pulling them over.

8. Your car does not have eyes—use yours when backing the car from the garage and driveway.

9. Be sure to store paints, turpentine, insecticide sprays, and other poisons out of children's reach.

10. Poison ivy and oak and sumac should be cleared from the yard.

11. Proper lighting for outside steps, terraces, and other areas used at night is protection against both accidents and burglaries. Outdoor wiring and lighting call for lamp sockets, convenience outlets, wiring, etc., of a special waterproof type. Your electrician will install proper types of materials.

12. Trash and rubbish that is burnable should be destroyed in a closed mesh wire basket. The burning should not be done on days when there is a strong wind. Before starting a fire in the yard, (1) make sure there is help to keep it under control, and (2) consider wind conditions and dryness of surrounding area.

13. Play space in the yard for children should be placed so adults can supervise play while at work inside the house. Young children should be placed in an area with a fence around it. Outdoor play equipment such as swings, slides, etc., should be checked frequently for defects.

14. Sudden small drops in grade should be eliminated as much as possible by proper design and grading.

15. For steep grades, terraces are safer than retaining walls. Plant the terrace with prickly shrubs to discourage short cuts, hold soil, and reduce maintenance.

16. Retaining walls should extend above the upper level or be topped by a fence which children will not be able to climb over or squeeze through.

17. Plan clearly visible fencing throughout. Never use barbed wire or low, inconspicuous wire to deflect traffic.

18. A uniform, nonslip surface should be provided for all walks, steps, and ramps. This surface should be comparable in traction to sand float or scored cement with no sprinkling of neat cement or use of a steel trowel in finishing.

19. Walks should have a crosswise draining slope of ¼ inch per foot, never more than ½ inch per foot. Locate the catch basin 2 feet or more from the walk, with the grating top about 3 inches below walk level.

20. Locate walks and steps, especially in areas of frequent freezing, where down spout or other water does not drain directly across or stand in puddles.

21. Teach older children the proper use of darts, BB guns, sling shots, and bow and arrows.

22. Teach older children the safe use of firearms if you permit them to go hunting or target shooting.

Suggestions for Making the Porch Safer

1. To prevent falls nonskid surfaces should be provided for porches, steps, paved walks, and driveways.

2. Any porch or platform that is more than 10 inches above grade should have a railing.

3. Outside steps, terraces, and other areas used at night should be lighted.

4. Ice and snow should be removed from porches, outside steps, and sidewalks as soon as possible. Salt, ashes, and sand are often used for icy walks and steps.

5. Outdoor lighting and sockets should be waterproofed.

6. Porch swings should be fastened securely to rafters in the porch roof.

E. D. PULLIAM, *formerly supervisor, Accident Control Section, Kentucky Department of Health, Louisville, Ky., states that this material is based on the surveys they conducted in Harrison and Marshall Counties. The preventive angles were worked up from many other sources of information. It was produced by the Accident Control Section of the Kentucky Department of Health and can be useful in planning a broadcast, 5-minute talk, a poster, or an exhibit.*

VOICE: So Help Me—It's the Truth!

ANNOUNCER: Station _____ and the Ohio State Safety Council present So Help Me—a 5 minute program featuring the Voice of Safety as he tells us some of the freak squeaks, the crazy goings-on as your fellow citizens got themselves involved in accidents. This evening, for instance, the Voice of Safety tells us about an angel who didn't quite make the grade "up there."

VOICE: So Help Me—It's the Truth!

This angel had a name—Bill Thompson—and an address—Atlanta, Georgia. Mr. Thompson hopes for the best in the hereafter, of course, but he also hopes he makes out better as a real angel than he did on his pilot run. Playing an angel in an amateur theatrical production, Mr. Thompson came down to earth with a bang when the cable supporting him broke as he floated in midair.

Your Voice of Safety is no angel —in any sense of the word—and has never had any angelic experiences, stage or otherwise, but he does know a little about people who go around walking on air. Invariably they find that they need something more substantial to support them. Occasionally we do have a job that calls for a rope to support us—or to hoist up tools and other material. Either job demands at least a one-half inch manila rope. Make sure that rope is fairly new, too. One that has been around the place a while may be worn or rotted and can't be trusted. Whether you use a block and tackle or a simple rope hoist, that rope determines your safety—make sure it's a good one.

However, most of the up-in-the-air-work an average guy performs is done on a ladder, and, brother, how people can get hurt using those things! A straight ladder should be set so that the base is one-fourth of its length from the wall. It should set firm at both the base and the top to avoid shifting as you work or climb on it. Don't play acrobat. Face the ladder while you're climbing, and use both hands to grasp the rungs or side rails as you climb. Never try to work from the under side of the ladder. Stay on top of it.

Every once in a while, you'll get a job that requires an elevated platform or scaffold. A single plank doesn't offer adequate footing or support. The scaffold should be at least two planks wide. Once you're up there, use a rope and bucket or basket to haul things aloft. Don't try to carry even small objects in your hands as you climb. Keep both hands free for climbing.

Probably most household chores aloft are done from a stepladder. Be sure to use one that's tall enough to reach the work without your getting on the top step. Working from a top step requires the balance of an acrobat. You probably don't have the talent for it so stay off the top. Another thing, be sure the ladder is firmly placed and that the spreader bars are latched to prevent the legs from closing under you. Put material and tools on the top step or the bucket shelf that's provided for that purpose. Don't get so much stuff on the ladder that it begins to fall off. And if you have to move the ladder, remove the tools first. The same applies when you leave the job for a while. Somebody might come along, bump the ladder, and knock something down on his head.

Don't leave ladders standing when you have to leave the job for a considerable time. It seems to be true that youngsters and some pets can't resist the temptation to climb a ladder. Yours truly was completely startled one day when a cat joined me at the top of a 28-foot ladder. The cat seemed to be perfectly safe, but I almost fell off from the surprise. Take your ladders down if you're going to be away for an hour or longer. Place them against the building where no one can trip over them.

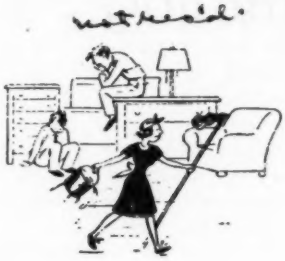
If you're working in a tree, use a ladder; don't rely on tree branches to support you. You may make an eight-point landing as Brother Thompson did on his maiden flight as an angel.

ANNOUNCER: You have been listening to So Help Me—presented by _____ each _____ at this time for the Ohio State Safety Council. The Voice of Safety will be back again next week with the story of another freak accident and some tips on how you and I can stay alive and healthy. So Help Me—It's the Truth!

So Help Me — It's the Truth!

This script was produced by the WGAR Broadcasting Company and the Ohio State Safety Council, Cleveland, Ohio. H. G. J. Hays, executive secretary and treasurer, Ohio State Safety Council, states that this is one of a series of scripts the anecdotes for which were derived from a number of sources, among them newspapers and the annual Freak Squeak story of the National Safety Council. Occasionally someone sends an anecdote to him.

SPRING CLEANUP



This radio script is from Miss Mae Frazier of the Johnson County Health Department in Kentucky. Johnson County is one of the counties conducting a home safety program under the auspices of the Kentucky Department of Health.

HOWDY! Is your spring cleaning done? Probably not, but I bet you've been *thinking* about it! Why not make this a time to think about *home safety* too? Spring cleaning and home safety go hand in hand because one of the *first* rules of *safety is good housekeeping.*

Here are some suggestions that might be helpful in *your* spring cleaning:

First of all plan your work so that you won't be doing too much in one day. If you become overtired, you are more apt to have an accident. Fatigue can be reduced by alternating heavy and light work. If some object or piece of furniture is too heavy for you to move by yourself, wait until you can get help. When lifting *always* bend the *knees* not the *back*. Improper lifting might cause painful and even permanent injury.

Check the equipment you are using for defects. For instance, if you are using a ladder, make sure there are no broken rungs or splits in the wood. Don't overreach when on a ladder—move the ladder.

When you are cleaning is a good time to arrange for convenient storage of equipment and supplies. Store these things near the area where you will be working with them. You will find this will save you many steps. And while we are talking about storage, how about placing such things as lye, furniture polish, kerosene, lighter fluid, bleach, rat poison, and insecticides out of the reach of small children? And those old medicines you aren't using anymore, get rid of them! If they are not already in the liquid form, dissolve them in water and bury them, or flush them down the toilet. The medicines you are still using, even aspirin, should be stored in a place where children can't get to them.

If you are going to wax the floors, use a nonskid wax. Apply floor wax in a thin coat, and buff it thoroughly to make it less slippery. It's not the thickness of wax, but it's the hardness which protects your floors.

Arrange furniture so that there are clear paths through all your rooms.

Don't give fire a chance to start in *your* home. A *clean* house seldom burns. Clear out all of your old newspapers, magazines, and unused clothing as well as unused paints, solvents, and oily rags. Oily dusting cloths should be stored in a closed metal or glass container when not in use.

Now don't stop when you've cleaned out the inside of your house. Go after the rubbish in the yard. Dispose of trash regularly and often. Don't let it pile up. If you are going to burn trash out of doors, choose a spot well away from the house and other buildings. Pick a day when there isn't a strong wind. Keep children away from the fire, and have some adult watch the fire. Don't try to burn too much at one time. Have a few pails of water ready in case the fire starts to spread. When you're done, make sure the fire is out. Soak the coals with water; stir to be sure all coals are wet. A gust of wind can fan up coals that are seemingly dead.

What are some of the other "booby traps" you can get rid of in your yard? Stumps, uneven places, holes, and rocks should be eliminated as they can cause falls. Nails, old lumber, glass, wire, and tin cans can cause falls as well as cuts and puncture wounds. All of these should be picked up and thrown away. Lawn mowers and garden tools can cause permanent injury. When a lawn mower is run over sticks and stones, these can fly up and cause serious bruises and other injuries. Don't leave the lawn mower and garden tools lying in the yard. Put them away when you're through using them. Check your clothesline. Is it high enough so that an adult can walk under it?

You will probably be pretty tired after doing all of these things, but *wait*—you're not through yet! The next suggestion I have is not such hard work, but it is important too. Go through the house, and check all of your electrical appliances and cords for defects. Those that need it, see that they are repaired.

Now you are probably pretty proud of how nice your house and yard looks. Why not get the family together and talk about how everyone can keep the place clean and safe all year round?

Inservice Education and Training

By F. Jean Williams

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In these times of pinning people to the wall with the question "What do you mean by that?" or the statement "It depends on your definition," it is necessary to state one's premise or definitions of terms in the beginning of a discussion.* Borrowing from Humpty Dumpty's philosophy, "When I use a word it means just what I choose it to mean —neither more nor less," let us consider these definitions of inservice education and training. "Inservice" means "an integral part of the time and activities of the work situation." Actually the term "inservice education" is giving way to "staff education" which permits broader consideration of preservice, inservice, and continuing education. "Education" means "learning that brings about a desirable change in knowledge, attitudes, and behavior." "Training" means "instruction and practice in specific activities and situations which are not necessarily appropriate in other situations."

The Real Purposes

In considering these definitions, let us also see them as a springboard for inquiry into the real purposes of learning endeavors. We are faced with a miscellany of understanding about the problem of accidental injury in the home. We recognize our need for action to reduce the problem. We are questioning how we can go about learning to meet it. We like to think that we can enhance our personal competencies and skills through learning while we work.

Employees with a particular job responsibility and volunteer workers are mutually concerned about improving the quality of their efforts in public service. The purposes toward which these efforts are to be directed will indicate the skills and understanding which they wish to develop. For example, if the purpose is to enable each member of a school faculty or a health department to provide safety instruction and accident control measures in his daily work, he will need to know more about safe design and management of the environment, about conditions in both the environment and the individual that may provoke accidents, and about ways in which he can motivate the individual to take action which will prevent accidents. If, on the other hand, the purpose is to stimulate general public awareness and understanding of the problem in the community, he will need to know more about public education media, group leadership techniques, and the resources in the community through which he can work.

It appears then that examination of why a staff wants to engage in an inservice learning experience is the point around which it may be built. A judicious examination of reasons for spending time on the subject will be the beginning of learning. If the reason is to develop understanding and skills which will lead to better performance of the task at hand, then first the task must be studied. What is the problem? Why may this staff undertake its solution? What is needed to accomplish it? Exploration of these questions, early in the planning phase, will not only be a learning process but will also suggest the framework for choosing instructional activities and content. Furthermore, it will point to the resources for instruction which may be explored.

In other words, if the staff wishes to concentrate on environmental improvement, they may look for information among architects, builders, electricians, home economists, and so on. If the group wish to study the behavioral and disease related factors, they may turn to social and psychological scientists and to medical and public health specialists. If the purpose is to engage largely in community education, instruction should be sought among such educators and experts in communications and visual aids techniques as journalists, radio and television specialists, and film producers and operators.

Defining Objectives

Subjects for study will practically name themselves as purposes and objectives are defined and understood. It is important to have the objectives for the learning experience defined by a group representative of all the participants in the course. Education and development of skill relates directly to learning ability and interest. If the members

*This is a speech entitled "Inservice Education and Training for Accident Prevention," presented October 24, 1956, at the 44th National Safety Congress and Exposition in Chicago, Ill.

of the group participate in identifying their needs and objectives for meeting them, they will naturally become interested in the outcome of their efforts. Through involvement in the planning process the individual may develop keener sensitivity to his needs. Granted there may be a gap between what he thinks he needs and what administrative or supervisory people think is necessary for accomplishing the job; still exercise in helping to plan the program will surely result in a broader awareness of subjects for learning. A plan prepared for and not with him misses this opportunity for creation of awareness and readiness to learn.

Instruction Activities

It is equally important that instruction and training activities are compatible with the learning abilities of the particular people involved. In safety and accident prevention work this is not always easy. It is a field in which a great variety of people can make a contribution. There is need for common understanding as well as for full development of the potentialities of everyone who enters the scene. It becomes increasingly important to have participants identify their feelings of need for education as the group increases in complexity of composition in educational, social, and experience backgrounds.

It is evident, too, that effective planning for an inservice education program requires guidance from one well versed in educational methods and learning principles. Important issues are at stake: Over all is the development of competency to meet a serious health problem; time of busy people is involved; bringing about a desirable change in the knowledge, attitudes, and skills of community workers is no light responsibility. Application of scientific educational principles in planning the program is good insurance against waste of time and effort. If an educator is not a part of the group planning for the program, surely a member of the local school system, of a community college, or of the adult education association would be willing to assist the group.

There is no magic formula for successful teaching and learning about accidents. The subject requires just as much thoughtful development as does any other great public problem. It requires specific identification of those parts of the problem which a given group may prepare to solve. It requires a sustained and increasing learning and not a flash of insight that whips interest into action that fades with the flash.

For many reasons those concerned with the educational program—planners, instructors, and participants—will want to know what the effort was worth. This can be known through planned efforts to relate the purposes, based on knowledge of the need, the mutually defined learning objectives, and the observable or known changes that take place in the attitudes, knowledge, skill, and performance of the group. These planned efforts can take the form of tests of knowledge and judgment developed during the course of study. These can only test learning achievement at the time through methods of recording and observing performance which reflects the content taught and more important by careful accumulation of data that will reflect changes in the problems—changes which are directly related to efforts of the worker before and after the learning experience.

Individual Effort

The success of an educational program may also be shown by the amount of individual effort to continue study of the subject that follows a learning experience. At best a short period of study or practice can only bring one into focus with current information and techniques and point the direction for continued improvement. Stimulation of sensitivity to the need, knowledge of current practices, and eagerness for improvement should be the springboard for and not the end of effort for acquiring more knowledge and skill. In a nutshell, if time and effort are going to be expended on inservice education, then tools for assessing its values should be planned and used throughout the course. They will not only help to focus the satisfactions realized from the effort; they will also provide supporting structure for introducing new material in keeping with the changing needs of the situation in the community and continuing development of staff competencies to meet them.

Staff Education

What are some of the ways and means of engaging in purposeful staff education for home accident prevention? Various methods have been tried by the 8 state and 4 local demonstration programs in home accident prevention supported by the W. K. Kellogg Foundation.

In the Department of Public Health, San Jose, Calif., the first year of their 5-year demonstration project was largely devoted to study of the problem and staff training. Separate study programs were conducted in the sanitation and nursing divisions, and joint meetings were held. At joint meetings activities were reported, problems were illustrated, and solutions discussed. The special home safety staff provided continuing stimulation and information. Evaluation of their efforts was done in terms of subjective responses of division administrators. A typical comment is, "Nurses who have been exposed to inservice education in home safety practice the principles of home safety in their field work more comfortably and more completely than nurses who have joined the staff without this training."†

In North Carolina, the Accident Prevention Section of the State Board of Health and the School of Public Health of the University of North Carolina have sponsored four short summer courses in home and farm accident prevention for local health department personnel from North Carolina and neighboring states. Twenty hours of instruction were given during a 1-week period. It was the writer's privilege to par-

†*San Jose Home Safety Project, A Five Year Report, 1951-1956*, p. 21, Department of Public Health, San Jose, Calif., 1956.

ticipate in the course in the summers of 1955 and 1956. In the last course, lecture, group discussion, and group project methods were used. Subjects were illustrated with visual aids and films. Groups were asked to work each day with the material presented so far toward answering a single question at the end of the week: "What may health departments do in accident prevention programs?"

Exciting lists of ideas resulted from their work. Some of them are: (1) "Throw out a formula to organizations for a program approach with a specific problem in mind and ways in which they may help." (2) "Find out what other agencies and organizations are doing . . . and try not to duplicate services, but fill in the gaps." (3) "Know the facts—education at home may relieve stresses that lead to accidents elsewhere." (4) "Practice safety ourselves; our own actions are our best teachers." From one of those courses a public health nurse went back to her schools and set up a scheduled class where children who had repeated accidents learned to understand some of the causes and how they could avoid them. A health officer went home and initiated a series of accident prevention articles in the county newspaper.

Another type of educational method was used in Oregon. The Governor's Committee on Home Safety, of which the executive secretary is also home safety consultant for the State Board of Health, conducted a 2-day workshop aimed at helping program chairmen of interested organizations as well as community workers plan effective programs. It was held at Reed College in Portland.

Six months prior to the workshop a questionnaire was sent to program chairmen to find out the needs in home safety education. The workshop, set up to meet those needs, concentrated in three areas: basic facts about Oregon's home accident problem, how to plan and present short programs, and how to plan a long range program aimed at obtaining and maintaining public interest. Small group discussion and project techniques were used. Skits and role playing were employed in the presentation of group reports. Two groups studied "planning and presenting short programs," and two studied "planning a long range community program." A rich body of ideas emerged from the workshop; a typical example was, "the value of telling the story so that an individual can apply it to himself."

The foregoing examples illustrate kinds of educational efforts that have been tried. Similar experiences have taken place in other home accident prevention demonstration programs in state departments of public health in California, Massachusetts, Maryland, Kentucky, Georgia, and Kansas. Experiences exist in other local health departments' demonstration programs in Kalamazoo, Mich.; Cambridge, Mass.; and Mansfield, Ohio. Other states and localities, too, without the stimulus of extra funds or a demonstration status, have been bending their efforts to preparation for work in home accident prevention, and new programs are emerging every day. Grand Rapids, Mich., Charleston, S. C., Alexandria, Va., Pennsylvania, New York, Indiana, Minnesota, Missouri, and Oklahoma are a few. The Home Safety Inventory for 1956 will reveal many others.

All of us here are a part of the fast growing body of people who want to know more about doing a tremendous job better. I have attempted to relate some of the time-tested principles of educational preparation and to describe some efforts that have worked. We *can* learn how to lift the horizons that will reveal a safer world.

For further information about some of the projects mentioned in Miss Williams' speech, see the following articles in the *Home Safety Review*.

1. "Safety in Massachusetts," Earl J. Anderson, March 1956.
2. "Kansas Award Program," A. F. Schaplowsky, April 1956.
3. "Charleston County Program," Gerald J. Specter, M.P.H., June 1956.
4. "Citywide Aspects," W. B. Prothro, M.D., September 1956.
5. "An Experience in Home Injury Prevention," Harry Wain, M.D., M.P.H., Harold E. Samuelson, M.P.H., and F. M. Hemphill, Ph.D., September 1956.
6. "The Missouri Story," James E. Downey, Jr., October 1956.
7. "Program Aids for a Publicity Campaign," Joseph F. Poges, November 1956.
8. "We Had a Workshop!", Janice Westaby, November 1956.
9. "Accident Prevention as an Integral Part of Environmental Sanitation," H. Earle Belue, November 1956.
10. "Publicity, Various Media," J. Charles Judge, December 1956.
11. "Maryland Program on Falls," Ethel L. Garrison, January 1957.
12. "The San Jose Experience," Dwight M. Bissell, M.D., February 1957.
13. "Using Health Councils," James E. Downey, Jr., February 1957.
14. "Involving Health Department Staff in Home Accident Prevention," Harold E. Samuelson, February 1957.
15. "Home Safety In Georgia," Henry C. Steed, Jr., March 1957.
16. "Adapting Ideas," Gerald J. Specter, this issue.
17. "Public Health Aspects," A. F. Schaplowsky, this issue.
18. "Full-Time Public Health Program," Hugh C. Sarraf, this issue.

Off-the-Job Leaflet

The Wisconsin State Board of Health, Madison, Wis., published this off-the-job leaflet for free distribution. The cover and the center spread are shown on this page.

SAFETY Pays
at Home too
Let's Put Industrial Safety "Know How" to Work at Home
FIRST, MAKE YOUR HOME SAFE
STORE ALL DANGEROUS HOUSEHOLD ITEMS PROPERLY – TOOLS, POISONS, MATCHES.
SEEK OUT FIRE HAZARDS SUCH AS RUBBISH IN ATTIC AND BASEMENT AND BUNDLES OF OILY RAGS AND CLEAR THEM OUT.
ELIMINATE ALL SKID HAZARDS ON FLOORS AND RUGS.
AND KEEP IT THAT WAY ALWAYS
REPAIR ALL BROKEN AND FAULTY EQUIPMENT IMMEDIATELY.
TAKE CARE NOT TO OVERLOAD ELECTRICAL CIRCUITS.
REPLACE TOOLS AFTER USING THEM.
KEEP YARD, GARAGE, AND HOUSE LITTER-FREE.
USE LADDERS – DON'T STAND ON WOBBLY BOXES OR SIMILAR MAKESHIFTS.
PACE YOURSELF IN YOUR HOUSEHOLD CHORES AND TAKE FREQUENT "BREAKS." FATIGUE CAUSES ACCIDENTS.
Practice Safety First – at Home!

ADAPTING IDEAS

By Gerald J. Specter
Public Health Educator
County Department of Health
Charleston, S. C.

One of the earliest frustrations which I faced at the beginning of my career in public health was determining a starting place. So many possibilities loomed in front of me, all of which seemed equally important. About the time when the situation became unbearable, a friend of mine gave me the answer.

With all my education, you would have thought that I could have solved this problem without help. Perhaps, but when one is busy looking at the trees it is so true that he often fails to see the forest. What this friend said to me was simply this: Do one thing at a time as best you can, and when further opportunity presents itself, take advantage of it. Basic advice, but sound indeed!

Now, I am not financially well-to-do. In fact most anyone I could approach probably has more money in the bank than I do. My intentions have been good. Often I have promised myself that I would start saving the very next pay day. Of course a good start is necessary. The trouble is the good start never materializes and, for me, the race has yet to begin. Perhaps we all would be much better off by listening to the announcer advertise the local bank when he urges you to "start with a little bit and watch it grow."

Since I am in public health, all matters in which community action are necessary are of vital interest to me. What would happen if we all sat back and waited for the day when the cure for cancer is announced? What would be our lot if research in other fields of medicine were based on an all or nothing program? The answer is self-evident. A great many lives would be lost. This is the case with home accident prevention. My remarks today are intended simply to tell you about some ideas that worked with us and perhaps provide you with a "little bit" with which to start so that you too may watch your home accident prevention program grow.

Now, I am a man who believes in saving time. If someone is doing something better, I believe it is

Mr. Specter

describes a project to interest people in home safety in a speech entitled "Stay Where You Are," presented October 22, 1956, at the 44th National Safety Congress in Chicago, Ill.

worthwhile to "adapt" some of the ideas into your own program. Bear in mind that many of us who are extremely concerned with home accidents cannot always find the time and money to develop new ideas and practices. When we are in this type of situation, there is no justification for sitting back and waiting for a miracle to change things.

The most eye-opening fact you will discover is that many others are equally interested in finding an answer to this problem. If there is no organized program in your area, find out what is being done on an individual basis by local groups such as clubs, PTA's, and other agencies. I am sure you have been told this before. Perhaps you need to be told again. This is the action we took and we have seen the good results that can be accomplished. Certainly our efforts were not momentous, but nevertheless they were a start in the right direction. We are drawing interest on our little investment. We might still be waiting to begin, if a waiting game is what we played.

We in the County Health Department, Charleston, S. C., certainly are concerned with protection of the public's health. When statistics tell us that more people are dying in home accidents than by polio, diphtheria, and tuberculosis, then there is ample justification for taking action. Through the health department's working in the community with others such as civic leaders, educators, and representatives of various agencies of the local government, a local Safety Council came into being. Of the six standing committees composing the council, traffic and home safety were in need of greatest emphasis. Our story here will deal with some of the short and long range objectives in our home accident prevention program.

One of the first steps necessary was the recruitment of members to serve on our home safety committee. This turned out to be much less difficult than expected. Upon checking local resources for individuals and groups interested, we found a good nucleus in the four local area Business and Professional Women's Clubs.* After meeting with representatives of the clubs and discussing the problem, they agreed to turn their efforts toward an all out home accident prevention program.

Until now, the clubs' efforts were more or less directed at their own membership. Efforts would now be aimed at community centered objectives. Like most communities, Charleston has its fair share of organizations, which range from the typical "knife and fork" groups to the area garden clubs, PTA's, and Church clubs. Knowing they all carried on a program at each meeting, the home safety committee felt the opening gambit of our campaign could be made through this channel.

Everyone likes a ready-made audience. It makes things so much more simple and lessens the amount of work required to find a target for the message. The problem is finding the proper audience that will translate what we have to offer into real action. Knowing that all clubs spend a good deal of time planning programs for their membership, we felt this could be the entré we needed.

Our home safety committee decided to work up home safety program kits to be distributed to clubs throughout the country. We wanted to make it easier for these clubs to put home accident prevention into their activities.

It was the general feeling of our committee that the program kit would have to be complete in every way. It would be necessary to spell out ways and means for conducting such a program. We knew a kit that could do this would simplify our job, since most of the work for conducting the program in terms of ideas, methods of presentation, and materials needed could be included.

Having good intentions but little money meant ingenuity was the order of the day. It is surprising how much can be accomplished with little or no financial help. I do not mean to over simplify the financial aspects of doing a home accident prevention job, but nevertheless our experience taught us that much can be done.

A small investment in postage and stationery brought us numerous ideas, materials, and other aids for preparation of a program kit. We borrowed, adapted, and appropriated in every possible manner. Certain portions of the kit were adapted to add local flavoring. Experience has proven that a story told with a home town setting will attract a more attentive ear.

With the content of our kit completed, we had each member of our committee distribute copies to clubs on a personal basis. This would tend to take the cold, business-like approach away from our relationship and at the same time establish a contact that could be followed up in the future when other projects were planned.

Our purpose in distributing the program kit was to get as many groups as possible to put on safety programs. We had the satisfaction of seeing them do this. Of course we realized that this was only the first step of a long range goal. Many more short range objectives that would involve individual families

*See "Charleston County Program," by Gerald J. Specter, M.P.H., *Home Safety Review*, vol. 13, No. 6, pp. 4-7, June, 1956.

were necessary to take us closer to our ultimate aim—making home accident prevention a part of each person's everyday way of life. Perhaps this sounds unrealistic and trite. Our answer is simply, "What could we lose?" We wanted to stop accidents and save lives. If we saved our life, then we were doing a job.

I have not attempted to prove that what is being described here today is new or unique. The newness involved is that something is being done that had not been done before. More was on the way.

Now that we had started the ball rolling with a campaign to encourage all organizations to conduct programs dealing with the home accident problem, our next step was to get into as many individual homes as possible with our message. We knew home accident prevention had to be made a personal problem. How to do this was our next step.

Safety has been stressed by parents and teachers for a long time. Why not ask the schools to assist by working home accident prevention into the ongoing program? A meeting with school administrators and teachers and finally parent groups brought approval for a home hazard hunt.

Sixth Grade Pupils

The suggestion was made that sixth grade pupils were old enough to be relied on and young enough to be very serious about the responsibility of participating. As a result 4,300 sixth grade children became the instrument whereby home accident prevention education would enter that many homes. It might be pointed out here that such groups as Scouts, 4-H, or others might participate in place of school children, if desired.

In the preparation of a checklist we found a great variety of checklists available. It was the feeling of our committee that, once again, something with a local flavor would be more helpful. Taking the best elements of a number of checklists, we produced one locally for use in the home hazard hunt. When finances are a factor, it is quite proper to use checklists, distributed free of charge, and still accomplish your purpose.

Of necessity there was a certain amount of preliminary interpretation necessary for those who were to participate. Information was compiled and distributed to all principals. Meetings in each school were held, and the project was discussed in terms of what was expected of the teacher, the pupil, and the parent.

Hazards Reported

More than 4,300 sixth grade pupils representing 127 classes in 76 schools participated in the project. The pupils, with their parents, checked their homes for 20 potential hazards. A report of hazards found and corrected was made to the teacher. The schools with the best record of corrections were presented with awards of merit. As a result, 4,293 hazards were found of which 3,800 corrections were reported. The program was carried on throughout the school year, one school district at a time. We were also very fortunate to have a local dairy participate by providing free ice cream to pupils participating.

Evaluating this project we find that a great many families were made specifically aware of home accident hazards. Teachers were able to integrate home safety education into classroom teaching with projects and demonstrations. Others in the community absorbed some of this awareness and requested that they undertake a similar project. Since the initial project began, over 3,000 Girl Scouts in this area conducted a home hazard hunt. Here then was a short range project which could produce results quickly and thus maintain a high interest level throughout. There was competition and a desire to do a better job than the other fellow, class, or scout troop.

This type of project has proven itself simple to initiate. It could be repeated over and over by any group desiring such an activity. There was a personal basis involved, and it was done directly in the individual home. Our aim had been to create awareness. The home hazard hunt was doing this and taking us one step nearer our goal—reducing the number of home accidents.

The situation described in this report attempts to point out that short, snappy, impact types of activities with short range objectives have a real place in the overall long range goal in home accident prevention.

In our case the long range goal is creating public awareness of the problem. Constant hammering away at the problem via the short range project tends to keep our message in front of the community and provides for a variety of participating activities.

If I have described nothing new to you, if I have made you feel that the approach has been over simplified, then I can only say these are the things that worked for us. We have created awareness. We know this from the number of groups and individuals who have participated in home safety programs. We know this from the decrease in the number of home fatalities. There is, for sure, much we haven't done and much we do not know. All I can say is simply that, if we had sat back and waited for the perfect approach to the problem, we would still be waiting.

Conclusion

In conclusion let me leave you with these thoughts. No activity, however small in scope, should be rejected if in the end it takes you one step nearer home accident prevention. Lack of money should not be a deterrent. Every community has an abundance of resources waiting to be uncovered. We found them and so can you.

Home safety, we have learned, cannot be forced upon people. We do have a job, however, to help the community to become aware of home accidents and want to do something about them. Regardless of the scope of our activities, large or small, each has great value if it helps create a single thread of awareness.

ACCIDENTAL POISONING IN CHILDREN

By Joseph R. Christian, M. D.
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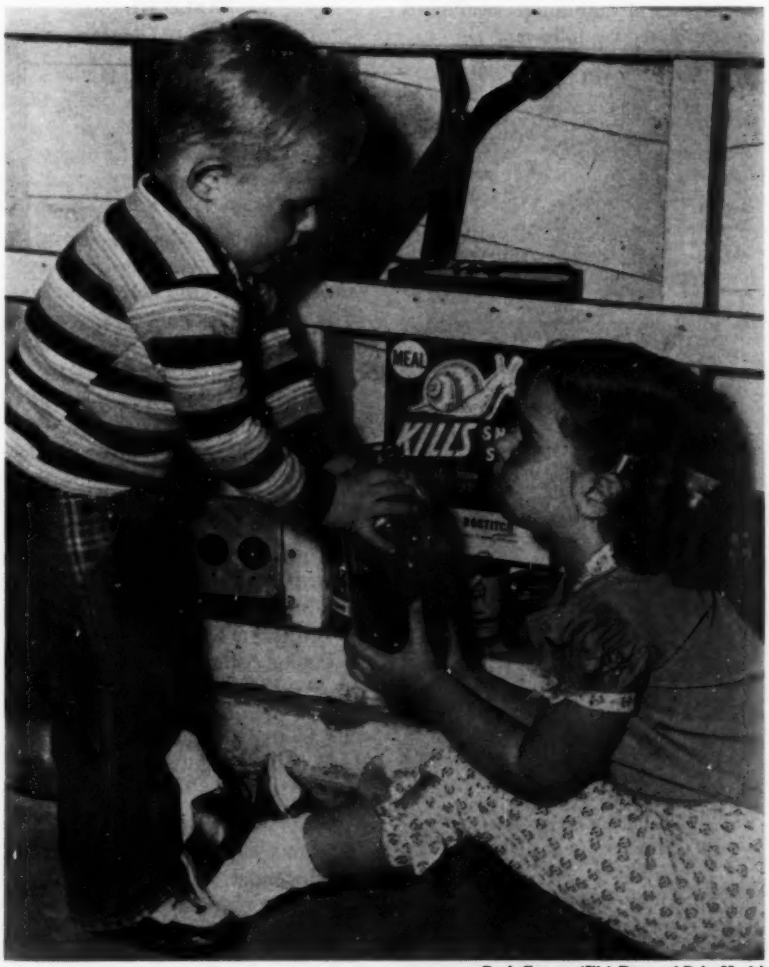


—Cook County (Ill.) Dept. of Pub. Health

Playmates Eric Marshall, 2, and Sandra Smith, 3, show why parents should take steps to prevent needless tragedy. Poisons should not be left carelessly around the garage, but should be stored on high shelves or in locked cabinets.

The problem of accidental injury, and especially accidental poisoning in infancy and childhood, has long been a great concern to professional and lay groups.* Inadequate precautions on the part of parents, physicians, and manufacturers of drugs and common household substances result in the ingestion of potentially toxic substances and the possibility of accidental death of a child. The dramatic and tragic result of negligence or an avoidable mistake on the part of an individual or group cannot be rationalized.

In 1950, the Accident Prevention Committee was appointed by the Amercan Academy of Pediatrics as a result of growing concern over the ever-increasing problems of accidental deaths in infancy and childhood. This nationwide committee was instrumental in encouraging state and local groups to analyze critically the size and scope of this multiphasic problem.

By November 1952 interest of several pediatricians in Illinois was stimulated and guided by Dr. Edward Press, a member of the Accident Prevention Committee, in the specific problem of accidental poisoning in children. The main objective proposed by Dr. Press was to minimize the damage from potentially toxic substances by improving efforts at prevention and treatment of accidental poisoning. On April 1, 1953, the first formal meeting of the Poison Control Committee of the Illinois Chapter of the American Academy of Pediatrics was held. This committee consisted of the following members: the chairman of the Department of Pediatrics of each of the five medical schools in Chicago, the chairman of a large general hospital, the State chairman of the American Academy of Pediatrics, representatives of the Chicago Board of Health, the State Toxicological Laboratory, the American Medical Association, the Federal Food and Drug Administration, and the National Safety Council.

Dr. Press was designated chairman of the committee and took

*This is a speech entitled "Accidental Poisoning in Children: Size and Scope of the Problem" presented October 22, 1956, at the 44th National Safety Congress and Exposition in Chicago, Ill.

upon himself the difficult and time-consuming task of compiling a reference guide to the chemical constituents of common household substances, together with treatment recommendations. A resulting 80-page looseleaf outline guide was submitted to all members for corrections, criticisms, and suggested revisions. This reference guide was then used as a basis for treatment of the patients seen in the emergency rooms of the hospitals associated with each of the pediatric members of the committee. The original six participating hospitals were: Bobs Roberts, Children's Memorial, Cook County, Mercy, Michael Reese, and Mount Sinai.

A poison control officer and an alternate were appointed for each of these hospitals. The responsibilities of this designated officer were: to instruct the professional personnel concerning the management of poison cases; to be responsible for having reference books, manuals, et cetera, available for use by the members of the staff; to give specific advice to the house staff or staff doctors concerning poison cases; and to report all cases to the Poison Control Center at the Chicago Board of Health on a form specifically developed for this program.

No specific therapy was recommended, but modification or complete change of the suggested treatment procedures set up in the reference manual was welcomed. Each poison control officer was free to use his own judgment, but each case, treated or untreated, was reported to the Center at the Chicago Board of Health. The reports were then analyzed and summarized by members of the Poison Control Committee and later mechanically tabulated to obtain as much useful information as possible.

To prevent recurrences of the specific accidental poisoning reported, the Chicago Board of Health's visiting nurses were utilized to make home visits. Evaluation was made of the home with respect to safety, existing conditions that might be remedied, and general health. A second followup report form was completed by the visiting public health nurse and returned to the Center at the Chicago Board of Health for a statistical analysis similar to the hospital report form.

After an initial pilot study from November 15, 1953, to March 10, 1954, the unanimous opinion of all members of the committee and the participating hospitals was that the program had tremendous possibilities. It was officially endorsed by the Chicago Medical Society and the Chicago Pediatric Society in April 1954, and subsequently all of the Chicago hospitals were invited to participate.

In May 1954, the first statistical breakdown of substances swallowed was tabulated as follows:

TABLE I.

(May 1954, Chicago Cases)

Type of Substance	Number		Percent
Medications		168	45
Internal	*115*		*31*
Aspirin	60		
Laxative	10		
Sedative	14		
Others	31		
External	*53*		*14*
Liniment	17		
K Mn 04	18		
Others	18		
Cleaning, Polishing and Sanitizing Agents		84	22
Bleach	35		
Lye	11		
Furniture Polish and Floor Polish	11		
Cleaning Fluid	6		
Lysol	9		
Others	12		
Petroleum Distillates (Including Kerosene)		46	12
Pesticides		41	11
Rodenticides	18		
Insecticides	23		
Turpentine		13	3
Other		20	5
Unknown		3	1
Total		375	100

In May 1955, a second statistical tabulation was made without any appreciable change in the percentage distribution:

TABLE II.

(May 1955, Chicago Cases)

Type of Substance	Number		Percent
Medications		523	50.6
Internal	*408*		*39.5*
Analgesic	210		
Sedative	69		
Laxative	28		
Cough Medicine	18		
Other	76		
Unknown	7		
External	*115*		*11.1*
Antiseptics	52		
Liniments	35		
Other	28		
Cleaning, Polishing and Sanitizing Agents		196	19.0
Bleach	78		
Disinfectant	34		
Furniture and Floor Polish	24		
Lye	23		
Cleaning Fluid	12		
Cleaning Agent	10		
Other	15		
Pesticides		107	10.4
Rodenticides	52		
Insecticides	48		
Others	7		
Petroleum Distillates		93	9.0
Fuel Oil	62		
Kerosene	23		
Lighter Fluid	8		
Turpentine		42	4.1
Cosmetics		19	1.8
Miscellaneous		46	4.5
Unknown		7	0.7
Total		1,033	100.0

In March 1956, a third statistical tabulation was made with similar results:

TABLE III.

(March 1956, Chicago Cases)

Type of Substance	Number		Percent
Medications		706	50.6
Internal	567	40.6	
External	139	10.0	
Cleaning, Polishing and Sanitizing Agents		276	19.8
Pesticides		147	10.5
Petroleum Distillates		110	7.9
Turpentine		51	3.7
Cosmetics		33	2.4
Miscellaneous		60	4.3
Unknown		11	0.8
Multiple		1	0.0
Total		1,395	100.0

The most strikingly apparent fact is that, in spite of the larger number of cases analyzed in the subsequent series, roughly 50 percent of the reported cases of poisoning were caused by the ingestion of medications, especially internal medications. Also of great significance in the statistical anlyses is the fact that aspirin is by far the most commonly occurring accidental poisoning in childhood. If this single fact can be confirmed in other centers throughout the country; that is, that 16-20 percent of all cases of accidental poisoning in childhood are due to the ingestion of aspirin, this fact alone would justify setting up Poison Control Centers in every city throughout the country.

From concrete facts such as these, recommendations to parents, physicians, and manufacturers can be established concerning the administration and storage in the home of drugs such as aspirin. Also, strong criticisms can be expressed against flavoring medications for the sake

of palatability with a resulting invitation for a child to ingest toxic amounts.

The preceding tabulations of the incidence and types of accidental poisoning in childhood in the Chicago Area have intensified the interest of hospitals, health departments, and other official and voluntary agencies as well as physicians at the local, state, and national levels. By November 1955, one year after the initiation of operation of the Chicago Poison Control Center, 14 cities had developed centers which were in actual operation and 9 additional cities had centers at various stages of development. Each of these centers developed organizational plans most feasible for their specific area; that is, some were primarily functioning as a part of an emergency service of a general hospital; others utilized the local health department; others originated as a part of the department of pediatrics of a medical school; and still others as a part of a service of the County Medical Society.

All of the centers record and tabulate the numbers and types of poisonings and offer facilities for emergency treatment either through the center itself or one of the local participating hospitals. By means of these records, which to the present time have been individualized, current information concerning the toxic constituents of pharmaceuticals, household products, et cetera, can be made available, and suggestions or recommendations for specific treatment can be available to physicians with the least possible delay.

From November 1953, when the first poison control committee was established, until July 1955, the number of cases reported daily in the Chicago Center steadily increased. However, after July 1955, in spite of a larger number of hospitals' participating in our program, there has been no appreciable increase in the total number of cases reported. The conclusion we would like to draw from this is that there has been some impact on the general public and professional people in their awareness of the problem and that accident prevention education of the public is beginning to bear fruit.

The problem of accidental poisoning is definitely a public health problem of such magnitude that the present system, which is a definite step in the right direction, provides inadequate facilities and service to vast areas. Without too much difficulty statewide programs could be set up utilizing the local medical health officer as the key figure. Through the local medical health officer each hospital in his area would be asked to participate in the program. The hospital participating would require that a poison control officer be appointed from and by its staff members. The duties of the poison control officer would be:

1. To be responsible for having books, reference manuals, et cetera, available for the staff members.
2. To instruct house officers and nurses concerning the management of poison cases.
3. To give specific advice to house staff or staff doctors concerning problem cases.
4. To report all cases on proper forms. The report form should be made out in triplicate. One copy would be sent to the local medical health officer, one copy to the State Department of Health where monthly statistical evaluations would be made, and one copy to the chairman of the Poison Control Committee. At intervals the statistical reports would be evaluated by the members of the committee and, when a particular poison seems to be prominent, communications would be issued to physicians and lay groups. Also, when a new poison is encountered, this committee would provide the latest information available on this substance.

Carelessness and lack of information on the part of parents, physicians, and manufacturers of drugs and common household substances have produced the problem of accidental poisoning in childhood. Therefore, it is imperative that each of us do everything possible to control this preventable problem by supplying a means of adequate emergency care and a well-planned educational program.

Ho 751 p

—National Safety Council

Drain cleaners, lye, and ammonia are some of the household cleansers which should be stored out of children's reach.

MEDICINE at WORK

Store poison in a properly labeled container, away from child's reach, not in a teacup where a child might find it.

PURSUING THE KILLERS NEW ALL-OUT WAR AGAINST POISONS*

BY THIS TIME tomorrow three persons will have died from accidental poisoning in the United States. Within the next 24 hours at least 425 will eat or drink something that neither they nor anyone else intended for human consumption, and they will turn up in hospital emergency rooms—sick but alive.

It is not cold-blooded to note that those shocking figures really represent encouraging news about an intensified battle against poisons. Ten years ago the casualty averages were twice as high: six deaths and over 850 nonfatal cases daily. How are these gains possible in a period of growing population and growing accessibility to so many new toxic substances among drug and household items? An answer lies in the fighting words of the question itself: Medical and nonmedical people have banded together to make headway in a new all-out war against poisons. In communities across the country, they are joining forces to halt the advance of an insidious foe that has killed some 15,000 Americans, including 5,000 young children, in the past decade.

Who are the poison fighters who helped save 150 lives in one year? They are the Boy Scouts of Troop 99 in Montclair, N. J., making door-to-door calls on 1,000 families to warn of dangers in home medicine chests. They are members of the Milwaukee Junior Chamber of Commerce sponsoring "Poison Day" —handing out warning leaflets in shops and on street corners. They are Rotarians, Lions, policemen, and firemen helping the Southbridge, Mass., board of health map out a safety program covering poisonous materials in the home.

Civic groups such as these, along with representatives from scores of industries, are on only one flank of the battle line. Medicine's assault is being waged through poison control centers, which the A.M.A. *Archives of Industrial Health,* recently described as "a new national movement."

Little more than three years ago, "poison control" was a meaningless phrase to most physicians. A doctor suddenly faced with an accidental poisoning case had nowhere to turn for expert help. Medical school training in toxicology was virtually nonexistent. Individual medical experience was useless when new synthetics happened to be the toxic agents. Only a few poorly circulated books and pamphlets were available with listings of specific poisons in some brand-name household chemicals. The result often was nothing more than first aid, occasionally the wrong kind of "first aid," in which induced vomiting of certain poisons led to pneumonia. There were needless deaths.

First Center Opens

Early in 1953 the first coordinated plan of attack took shape. Called to the initial blueprint session were chairmen of the pediatrics departments of the five Chicago medical schools, officials of the city board of health, the head of a large Chicago hospital, and representatives of the American Medical Association, the National Safety Council, the federal Food and Drug Administration, and the Illinois state toxicological laboratory. They decided it was time for action. The previous year 550 children had died of accidental poisoning in the United States—the highest toll since the end of World War II. Moreover, thousands of new products, potentially poisonous and with ingredients

*This article has been reprinted from the *Journal of the American Medical Association,* vol. 163, No. 2, pp. 114-117, January 12, 1957.

not on the labels, were flooding the consumer market. Flavored aspirin, which at that time had been available for over-the-counter sale in drug stores for less than five years, already was quadrupling prewar rates of deaths due to aspirin poisoning among preschool-age children.

In November 1953 the nation's first poison control center went into operation in Chicago. The first director, Dr. Edward Press, began establishing bench marks on the most dangerous poisons, on the estimated ratio of nonfatal to fatal cases (more than 125 live for each one who dies), and on the influence of candy medicaments. At the same time he tackled the huge double task of educating physicians to make use of the service and of enlisting the aid of various industry consultants to identify poisonous chemicals in their products. Somehow, Dr. Press also managed to respond to pleas of other cities where increased poisoning threats were creating a desperate need for more control centers.

Today, with nearly 2,000 cases logged, the Chicago center still operates in a Near South Side clinic building. Dr. Joseph Christian, associate professor of pediatrics at Loyola University, has taken over the unpaid job of director from Dr. Press, who now is field director of the American Public Health Association and a member of the A.M.A. Committee on Toxicology.

So far, that pioneer venture has fostered similar poison control services for physicians in 35 other U. S. cities. New ones are being formed at the rate of nearly two a month. Canada's first two poison control centers, organized largely on the Chicago plan, were slated to go into operation this month. Chicago's system this year is being decentralized, so that calls from physicians may be made to any of six strategically located hospitals (Cook County, Children's Memorial, Illinois Research, Michael Reese, Mount Sinai, and Bobs Roberts) where pediatricians skilled in treatment of cases of poisoning will be on duty around the clock.

Says Dr. Christian: "We hope to make this a part of each hospital's residency training. Eventually, all other Chicago hospitals may become sub-centers for relaying calls to the six basic points. We work only through doctors and hospitals because telephoned treatment can so easily be misconstrued by hysterical parents, and death might result."

Only First-Aid Advice

It is generally true in other poison control centers, too, that the public is urged to phone a doctor first and that only first-aid advice is given to nonmedical callers. Dr. Press notes that, probably because of this policy, no medicolegal problems have arisen. As more of the public become aware of these poison control centers, however, many parents are bound to disregard such advice. This is illustrated in the cases of "the two Seattle Suzies," whose mothers read about that city's new poison control center in a newspaper.

Susan Kimes' mother phoned the center to say that the 2½-year-old girl had swallowed a certain brand of blue shoe polish. A quick check showed that the polish was harmless. Then the mother of 3-year-old Susan Raymond telephoned with the tearful report that her daughter had locked herself in the bathroom and had swallowed 50 baby aspirins. The immediate telephoned first-aid advice was: "Bring the child to orthopedic hospital right away for a stomach lavage." The girl survived.

Practically all poison control centers in the U. S. represent joint action by various groups, medical and nonmedical. Cooperative agencies include all 116 hospitals in New York City, an industrial laboratory in Michigan, and the pesticide department of a state agricultural school. Also taking part in these programs are health departments, pharmacy colleges, coroner and medical examiner offices, visiting nurse associations, and medical societies. In Boston, help is solicited far and wide; the poison control center at Children's hospital there is operated as a service for physicians everywhere in the country on a 24-hour basis. There is no charge, except in contacting specialists.

Public alertness to the poison danger is reflected in the National Safety Council's past five years of mortality figures (children comprise about one-third of the deaths, with 9 out of 10 of such fatalities in children in the preschool-age group). In 1952, before the first

Wash utensils used for measuring poison as soon as the poison is measured to prevent child from swallowing it.

control center was established, the recorded poison death toll was 1,500.† When Chicago went into action the next year, amid anti-poison rumblings elsewhere in the nation, the total dropped to 1,450.

In 1954, after the Chicago center's first full year of operation had inspired 14 more centers across the country, there was a drop to 1,400 deaths. In 1955 (the last year of available figures), the toll from accidental poisonings took a sharp drop to 1,250. Unofficial figures for 1956 indicate another reduction to around 1,100 deaths. Says Dr. Christian: "The conclusion we would like to draw from this is that there has been some impact on the general public, and that accident prevention education is beginning to bear fruit."

The Fight Is Intensified

Instead of resting on these apparent laurels, both medical and nonmedical groups are intensifying the fight, with more poison control centers, more public education, and more vigilance of the estimated 250,000 unlabeled and potentially poisonous everyday products sold in stores. These are the latest developments aiming at victory over venom:

—The nation's top medical experts on poisoning are planning to meet soon in Washington, D. C., with public health officials and interested lay authorities. Their aim: to establish a clearinghouse for exchange of vital information from the various poison control centers.

—The A. M. A. Committee on Toxicology, armed with case reports of poisonings, is now working on a "model" law to require labeling of the many household chemicals that do not list toxic ingredients. These include paints and paint removers, heating and cooking fuels, art supplies, cleaning compounds, and some toys. Joining in this effort to initiate legislation are representatives of industry, medicine, and government. It is hoped the model "enabling law" for states will be in draft form within a year.

—The FDA is working with the American Association of Medical Record Librarians in a move to set up hospital studies that would indicate potential poisoning aspects of "therapeutic agents."

—The A. M. A. has recently established a permanent subcommittee with the mission of improving public education in chemical poisons.

—There is a renewed movement to urge teaching of toxicology in more medical schools. Six now have it as a separate subject, toxicology is brushed over lightly as an "integrated topic" within a variety of courses in other schools, and many do not teach it at all.

—The American Association of Pediatrics, a pioneer poison fighter, has joined with the A. M. A., the American Public Health Association, major medical centers and schools, and the poison control centers in a new clinical study of treatment against one of the toughest poisons to counteract: kerosene. Medical advisors for the petroleum industry also are taking part in this study—as consultants and as idea men for educating the public in handling kerosene.

—With some financial aid from the Proprietary Association (of over-the-counter drug wholesalers), this month the National Safety Council and the National Advertising Council are launching a countrywide newspaper advertising campaign emphasizing poison hazards in the home.

Communities Also in the Fight

Poisons get slapped around at the local level too. In San Francisco, the medical societies of nine Bay Area counties join with business and industry in helping finance the northern-California poison control center (the local chapter of the National Safety Council donates office facilities, and help also comes from the city health department). In Berkeley, Calif., a list of common potential poisons in the home is mailed with every birth certificate.

The Ohio Federation of Women's Clubs joins with the Ohio Safety Council in a weekly radio series on poisons, in a pamphlet campaign for local public health departments, and in preparing outlines on accidental poisoning for pediatricians addressing groups throughout the state. School health workers in Richmond, Va., draft a public education campaign designed to inspire the nation's 30 million school children as "watchdogs for chemical safety" by means of poster and essay contests and similar incentive methods. At Denver's poison control center, industrial experts volunteer as consultants on poisons that are in their respective products; offers of help come also from Rotary Clubs, Parent Teacher Associations, and the League of Women Voters. In Nebraska, the Chamber of Commerce, 4-H Clubs, Future Farmers of America, Boy and Girl Scouts, women's clubs, veterans' groups, nurses, policemen, and firemen help the state health department run a survey on poisonous household chemicals.

On a less organized scale, individual physicians in scattered parts of the country are using their office bulletin boards for public education. They are listing highlight poison cases that occur in their communities each week.

In spite of this widespread action, the push against poisonings will always be a tooth-and-nail tug of war. It has to be, because the threat is mounting. Compared to 25 years ago, today there are many more common household substances that can be poisonous: detergents and stimulants, rodenticides and insecticides, photography fixes, and plaster mixes. In addition, the U. S. public spends an estimated 1 billion dollars a year on prescription drugs and about a billion and a quarter more on packaged medicines.

Says Dr. Edward Press: "At the rate that new chemical compounds are being synthesized and distributed

†The author has used the National Safety Council's *Accident Facts*, 1953, 1954, 1955, and 1956 editions, as the sources of the statistics upon which he has based his conclusions. However, the statistics in reports from the N.O.V.S. received subsequently to the publication of these editions are as follows (see *Accident Facts* 1956, page 15): 1952, 1,440 deaths from poison all ages; 1953, 1,391; 1954, 1,339; 1955, 1,431 (N.O.V.S.); and the estimate of the National Safety Council for 1956 is now 1,300 such deaths.

The fact that the total deaths due to poisons has not risen as rapidly as the population from 1952 through 1955 indicates the effectiveness of this program. If the deaths had kept pace, the yearly total in 1956 would have been approximately 1,550.

with the aid of modern advertising and merchandising methods, an even greater accident threat to health from poisoning is likely in the future." He calls upon family physicians everywhere to prevent child poisonings by offering constant caution during home and office visits, and he adds: "Such advice almost always is well received because parents interpret it as a mark of the physician's sincerity and concern for health. This is excellent public relations as well as good preventive medicine."

In one California community late this spring a 3-year-old boy gulped down a red liquid, went into convulsions, and lapsed into a coma, which was interpreted as restful sleep by the family doctor. A few hours later the boy died of strychnine poisoning from the red rodenticide. Had the physician been able to telephone the brand name of the rodenticide immediately to the poison center in San Francisco, he might have saved the boy's life.

Lead and Carbon Tetrachloride

There is still much to learn about some poisons and the symptoms they cause. How many deaths are attributed to other causes after the victim's extreme exposure to carbon tetrachloride? This cleaning fluid is described by New York City Poison Control director Harry Rabin as "so vicious that it should be banned from every home." Carbon tetrachloride poisoning still often is confused with hepatitis, nephritis, and other ailments. How many cases of lead poisoning are never diagnosed because of its insidious build-up to permanent brain damage over a period of years, without a clue to the real cause? Not long ago doctors at the University of Maryland school of medicine tested 350 youngsters brought in consecutively to the children's clinic for a variety of reasons, ranging from mumps to arm fractures. The sampling results showed excess lead concentration in nearly half of the boys and girls. One boy was poisoned after nibbling on his crib's new coat of lead paint—brushed on by his father, a physician.

Store poisons in containers not usually used for foods, properly labeled, not as shown here in a jar the shape of which might lead a child to think it contains food.

Poisonous household drugs and chemicals seem to be a culinary challenge to many a child, and usually the unthinking parents are to blame. A baby drinks rat poison from a teacup; an infant sucks on a spoon used to mix chlorophenothane (DDT) plant spray; and another child swallows turpentine kept in a mayonnaise jar—or benzine in a coffee can, or bleach in a drinking glass.

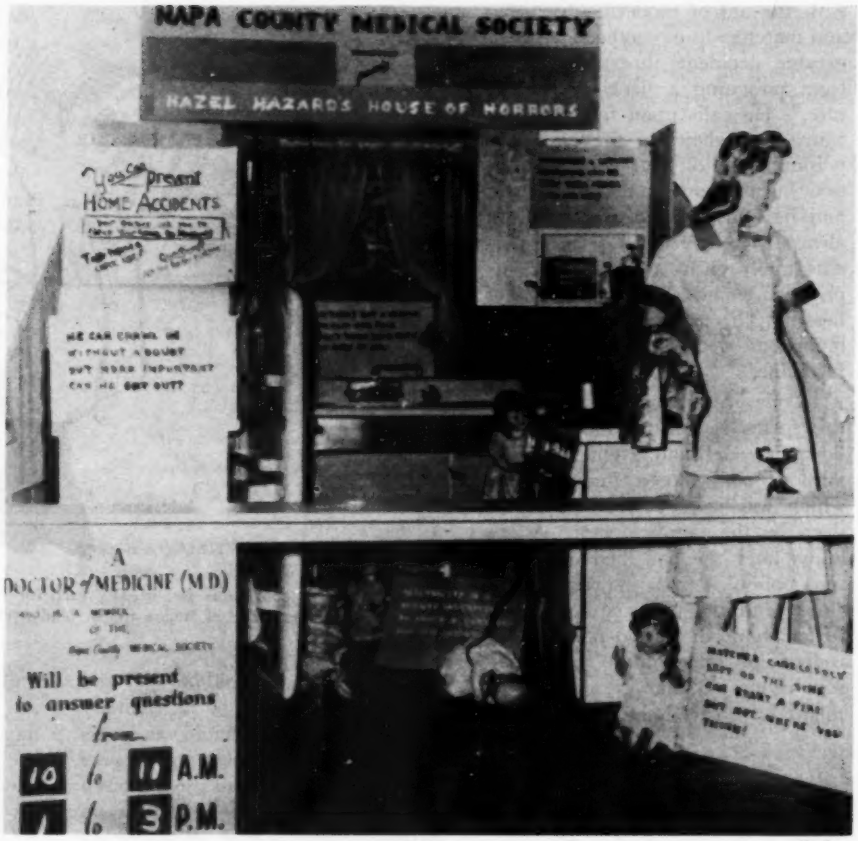
Variety of Candy Medicines

Meanwhile, business is booming in the sale of lollipop and chewing gum aspirin, orange-flavored vitamin tablets, chocolate and custard flavored antibiotics, fruit-flavored sulfonamide syrups, heart-shaped candy for epilepsy, rock-candy barbiturates, and clown-shaped bottles of other medicines. Candy medication has become an industry within the pharmaceutical industry, and even though there is an honest effort by most drug manufacturers to play down palatability to the general public, advertising agencies report that production is rising because of consumer demand.

While most pediatricians fight the trend to more and more candy medicants because of the poisoning potential, many general practitioners are not entirely convinced that a danger actually exists in the flavor itself. They justify properly guarded candy medicaments as the only form in which some children can be treated. And the general practitioners insist that the taste itself is not a responsible factor, because children tend to eat a number of nonedible substances without regard to flavor, simply because the stuff is left within reach of young hands.

In downstate Illinois not long ago, a young girl's hands reached for a delicious-colored bottle of red ink on her father's desk. Moments later, she was in a doctor's office—a shocking sight to pedestrians, waiting patients, and even the physician. Blood-like streaks, mingled with tears, covered her face, neck, and clothing. The doctor washed out her stomach and put in a rush call to the Chicago poison control center. A quick check of the brand name brought this telephoned response: "That ink is harmless—she could drink a gallon of the stuff safely." You can imagine the relief at the other end of the line. It was one medical bill paid with extra gratitude—that case in the physician's ledger did not go down in red ink.

Medical Society's Exhibit



The Napa County Medical Society's District Fair booth.

—Cathey

By Edward R. Pinckney, M.D.
Director of Public Health
Napa County Department of Public Health
Napa, Calif.

The members of the Napa County Medical Society, Napa, Calif., who are always stressing preventive medicine to their patients through immunizations and check-ups, decided to go one step further last year and display immunization techniques against home accidents. Through careful planning with the health department, with an interested merchant (Baylinson Appliances), and with one interested lay person with a background in sociology (Mervin Johnson of Napa, Calif.), the society requested space at the County District Fair which draws an attendance of 125,000 people.

Although they were offered a display booth of only 8 by 10 feet, they had ample room to set up what they called "Hazel Hazard's House of Horrors" (with apologies to the Prudential Insurance Company of America). The society further decided that an exhibit, per se, was not enough, and over half of the members volunteered to spend their time for hours on end to explain actually to the public not only how to avoid home accidents but what type of first aid to administer if such tragedy should occur.

The sight of a familiar home town physician standing behind a booth attracted a continuous crowd. When the physician took the time to explain health hazards in the home as well as to offer a "checklist" to take home in order to survey one's own property, many persons were quite enthralled that the medical profession was taking such an active interest.

It was certainly not out of line, however, for the physicians constantly referred to the fact that preventive medicine fits all fields of health. The teaching of safety in the home was as much a part of their job as the necessary treatment of the illness *after* it happened.

The booth actually portrayed Mrs. Hazard gossiping with friends on the telephone with her back turned on her 10 children. Of course, one couldn't help but wonder how Mrs. Hazard wound up with 10 children with tragedies such as were depicted constantly occurring.

Catch slogans were placed at each hazard. To quote a few:

"Electricity is a
Mighty invention.
To shock a baby
Was not its intention.

"Medicine and lotions, poisoners can be;

(to page 31)

FOR CLUBS TO MAKE SURVEYS

ACCIDENT REPORT

NAME _____ ADDRESS _____

DATE _____ TIME OF DAY _____ AGE _____ SEX _____ LOST TIME – NUMBER OF DAYS _____

PLACE OF ACCIDENT: _____
BARN, KITCHEN, FIELD, ETC.

ACTIVITY AT TIME OF ACCIDENT: _____
HOUSEWORK, PLAYING, CHORES, ETC.

TYPE OF ACCIDENT: _____
FALL, BURN, COLLISION, ELECTROCUTION, ETC.

AGENCY INVOLVED: _____
TRACTOR, COWS, BULL, GUN, KNIFE, ETC.

COST OF ACCIDENT: _____ EXTENT OF INJURY ( ) FATAL ( ) PERMANENT ( ) TEMPORARY
MEDICAL

REMARKS: _____

REPORTER _____ _____
NAME ADDRESS

SUGGESTED HOME SAFETY PROGRAM FOR ORGANIZATIONS

ACCIDENT SURVEY

An excellent way for a group to start a home safety program is to determine what the problem is in the community. This can be done by setting up an accident reporting system within the group. One method is to have each member report every accident that occurs to him or any member of his family or within his assigned area. An accident report pad located in a convenient place in the home can be used to record essential information about each accident. Accidents to be reported are all those which cause loss of time, property damage, or injury to life.

At each meeting the individual member brings his reports of accidents occurring since the last meeting. These reports are then consolidated on the organization's report sheet. The length of time this reporting procedure should be continued can be determined by the group but must continue long enough to give a true year-around picture of accidents in the community. It is suggested that reporting be continuous for one year. If this is too burdensome the group may decide to select one month during each season of the year to report, such as February, May, August and November.

At the end of the reporting period a tabulation of data should then be made to determine what accidents occur most frequently, where they occur, age group involved, etc. When this has been done a program can be directed at the most important problems.

The Home Safety Program of the Kansas State Board of Health can assist you by supplying report pads and organization report sheets. It can also help you analyze your accident data and plan your program. Home Safety posters, pamphlets and films are available upon request, without charge, from the

KANSAS HOME SAFETY PROGRAM
KANSAS STATE BOARD OF HEALTH
TOPEKA, KANSAS

ONE OF THE projects of the Kansas State Board of Health, Topeka, Kans., was to suggest that groups conduct a home accident survey among their own members. The accident report card and program suggestions shown were published, therefore, for this purpose.

PUBLIC HEALTH ASPECTS

By A. F. Schaplowsky

Director
Division of Health Education Services
Kansas State Board of Health
Topeka, Kans.

"Then people blamed demons and devils for disease—so today they blame luck or chance for accidents."

My remarks today must of necessity be based on my experience with the Home Safety Program in Kansas.*

At the outset I would like to mention several of my observations or impressions of home accident prevention activities as they relate to a state health department. My feeling as to placement of the program in the administrative structure is perhaps prejudiced, but it seems to me that, since the program as I see it is largely one of inservice training, stimulation, and assisting communities, state and local organizations, and local health departments to plan and develop programs, it should logically be placed in the Division of Health Education. It also seems to me that much can be done at state level with a relatively small staff. For a state like Kansas I feel that one or two individuals working full-time can develop a successful program. The Kansas program was developed with two staff members who devoted full-time to home safety.

It might be helpful at this point if I were to describe briefly the Kansas program.† Its activities can be divided into four general areas.

The first of these we might call "publicity and research." This included a statewide program of newspaper, TV, and radio publicity. The production or purchase and distribution of pamphlets, posters, exhibits, and films was also a part of this area of activity. The research activities included the development of studies of nonfatal home injuries with Kansas Blue Shield and a number of countywide studies with Home Demonstration Units. It also involved a study of the beliefs and attitudes about safety held by high school home economics students.

The second general area of activity we might refer to as "inservice training projects with State and local public health workers." In this category we might list the State Home Safety Advisory Committee which was made up of heads of several other divisions of the State Board of Health. A series of regional institutes on home safety for nurses was also held. Activities in this area also included our work with the staffs of local health departments by helping them to understand and to attempt to develop local programs.

The third general area of activity in the Kansas program we could call "working with other State organizations and agencies." Here we could list our projects developed with Home Demonstration Unit leaders, Kansas Congress of Parents and Teachers, Kansas Federated Women's Clubs, Kansas Farm Bureau, the State Association of Insurance Agents, Kansas BPW Clubs, State Chamber of Commerce, the Kansas Home Economics Association, the State Safety Council, and others.

The fourth general area involved our work directly with local organizations and groups throughout the State. This would include all the various civic and fraternal organizations as well as the numerous community groups and clubs. These were served in various ways such as supplying them with materials, ideas, and other resources.

This, very briefly, has been a description of the Kansas Home Safety Program.

Since I have been involved in home safety work, a number of things have been of interest to me

*This is a speech entitled "Public Health Aspects of Home Safety Programs" presented October 19, 1955, at the 43rd National Safety Congress and Exposition in Chicago, Ill.

†See "Kansas Award Program," by A. F. Schaplowsky, *Home Safety Review*, vol. 13, No. 4, pp. 10-12, April 1956.

which did not occur to me before. I should like to mention several of these as they may also be of interest to you.

One of the first things that impressed me was the fact that safety programs are definitely good public relations programs for the health departments. There is a great deal of acceptance of them by medical societies, physicians, and the people in general. It was also quite apparent that this is one public health program of which non-medically-trained people can play as important a part in the solving as can the scientists and doctors.

It also became very apparent to me that safety, in the minds of most people, is a negative thing. The mere mention of the word "safety" means that something will be taken out of their lives. In several studies with high school students we were able to learn that there is a very common misconception as to the causes of accidents. Luck or chance still seem to be the causes listed most frequently by most individuals. With some reflection on this point, however, this misconception might be compared to the beliefs of people before the specific causes for many diseases were discovered. Then people blamed demons and devils for disease—so today they blame luck or chance for accidents.

We learned that there is a certain amount of contagiousness about safety programs. Once one group started, others began hearing about it and inquiring if they couldn't get into the program also. This was especially true of Home Demonstration Units. We had planned to limit our activities to 5 or 6 counties, but requests came from neighboring counties, and we gave assistance to as many as we could and at one time had as many as 30 counties engaged in home safety activities.

One can read in the literature of two types of approaches to the accident prevention program by health departments, both apparently have a certain amount of success. I am referring of course to the Kalamazoo project where the approach seemed to be countywide with an attempt to involve as many people as possible and with the use of a tremendous amount of radio and newspaper publicity. The other approach is that demonstrated by Washtenaw County where a specific tool such as a Safety Calendar was used in a selected number of homes and repeated conferences were held with members of this household and staff members of the health department. Both of these methods apparently were successful. I feel that we in Kansas have tried to incorporate some of both of the approaches in our program.

We believe that there is a contribution that every discipline in public health can make toward the reduction of home accidents. To help all public health workers understand their role is an important part of the activities of a home safety program at State level. In general it seems to us, if we are to reduce the numbers of injuries and deaths caused by accidents in the home, all of our activities must obtain the greatest participation possible and must also provide the greatest possible educational experience for all the participants. This, of course, is not an easy job. Had it been easy, it would have been done long ago. As others have said, "The most challenging public health problems are still before us."

From my experience as the administrator of the program in Kansas, I would like to leave you with just one more thought. Working with a program of this type, I found it very difficult to plan my time carefully so as not to spend more time on certain phases of the program than on others. For example, I believe it would be very easy for an individual who liked to work with the development of materials and publicity to devote an undue amount of time to this phase of the program and thereby perhaps neglect the other areas of need.

In conclusion I would like to say that I believe home safety is a good program for any health department, and if we in public health do not expect to lose the confidence that the public has in public health, we had better exert more leadership in this field.

Full-Time Public Health Program

By Hugh C. Sarraf

Senior Sanitarian
Division of Home Accident Prevention
Pennsylvania Department of Health
Harrisburg, Pa.

The Commonwealth of Pennsylvania is basically not different from any other state.* We have a good health department that is progressively getting better. Some years ago our health department was surveyed by the American Public Health Association. In the report of this survey, recommendations were made among which were those pertaining to home safety. They said:

Although many agencies and other organizations are already engaged in accident prevention, the loss of life and the disabling due to accidental causes are far from ideal. It is therefore recommended:

1. That the Pennsylvania Department of Health establish a division of accident prevention with an adequate well-trained staff.
2. That the division conduct an intensive accident prevention program, concentrating on the prevention of home accidents in particular and of all other types of accidents in cooperation with other organizations already engaged in that activity.

Accident prevention is not new to the work of health department personnel. The definition of public

*This is a speech entitled "Home Safety as a Full-Time Public Health Program" presented October 19, 1955, at the 43rd National Safety Congress and Exposition in Chicago, Ill.

health states that it shall be the duty of public health workers to devise ways and means of conserving the health of the members of a community. As the need arose, each individual bureau of the state and local health departments took steps to incorporate safety into their work. This activity was found to be insufficient, for the number of people being killed annually in our state still remained around the 2,000 mark, not to mention the number of permanent disabilities. This is not a record of home accidents to be proud of. It was a stimulating thing, however, for on March 1, 1955, the Pennsylvania Department of Health initiated a program of home accident prevention.

Methods

As was previously stated, safety had already been a part of health department activities. It lacked coordination and above all it lacked something basic; that is, a method of formulation and evaluation. In order to coordinate, formulate, and evaluate, it must be done on a local level to be effective. These methods had to be devised along with an accumulation of the materials needed to cope with the problem for local organizations. This is the primary objective of the Pennsylvania state home accident program.

Out of necessity, home accident prevention must be a full-time public health program. It must be systematic, practical, growing, and alive. The problem is large enough to merit the attention of the department on a full-time basis. It is not just a problem for one division or bureau alone, nor is it one that can be solved only by the health department. It involves Sanitation, Nursing, Health Education, Nutrition, Maternal and Child Health, Preventive Medicine, Industrial Hygiene, and Statistics.

More than that, it is a program to lower the incidence of home accidents in a community; therefore, the chief actors in this role must be the communities themselves. All health workers concerned with home safety must be properly trained in safety techniques and this training put to effective, constant use. Safety is not a one-shot thing. If it were, our jobs would be simple. It must be full-time and not permitted to be lulled into a lethargy. It has been said that one lesson does not constitute an education, nor does one pamphlet or visit constitute a home safety program. It must be steady, organized, and constantly, critically analyzed by everyone so that steps for betterment can be taken. Each accident must be dealt with as an individual case because no two people are the same.

In order to point out how home safety is a full-time program, let me cite the example of my own state. We have established the Division of Home Accident Prevention within the Bureau of Environmental Safety. Thus far, we have one person full-time to act as coordinator. This coordinator has the assistance of a Plan Review Committee composed of members of the various bureaus who will be intimately concerned with the program operation. This committee functions to assist in planning, to approve methods of operation, and to provide comments and criticism of the plans of the coordinator. This is functioning effectively as a means of grouping our own forces within the department.

Because this program is a protective device for communities, contacts are made to state organizations that are carrying on safety projects. Our assistance is offered to them as a service, and methods planned how we, as an official agency, can best meet their needs to further their work. Other states are doing similar work, and it is with their help that our program has been started.

Epidemiological Followup

A plan has been devised and approval given whereby we will utilize hospitals, physicians, nursing, and convalescent homes to provide leads for an epidemiological followup by our nurses, sanitarians, and case workers. This is done locally either by a city or county health department or by a health district or region of the state health department. Budgetary provisions are already being made by many of our local units to conduct such full-time programs so that every accident can be investigated and every home involved inspected.

This takes a lot of time on the part of staff members, but in order to facilitate the job, a training program is being given for all public health personnel and for those people who have an active part in the program so that each can be a "seeing eye" as they visit each home. This program is divided into 10 separate lectures that are to be given by experts of each particular phase of accident prevention. In order to keep the program alive and functioning locally a coordinator is appointed and given the full responsibility to see that the program works.

Curriculums

There are ways and means of preventing accidents to the vast majority of the population who are not covered by the epidemiological approach. This involves the education of the people. Arrangements are being made to include home safety in the curriculums of several of our universities, colleges, high schools, and elementary and trade schools. A curriculum for a nursing school is already in the making. This is being planned by the director of nursing at that particular school and will, if successful, be made available to others. A similar type study plan is being tried in one of our elementary schools. It has as its basis the formation of a safety club. It is not, however, limited to home safety, but it does allow approximately 35 percent of its activity to our program of home accident prevention. Seasonal and other community projects will be carried on so that the theme of safety is kept before the public.

Home safety is a full-time public health program and must be kept that way. As long as people are on the earth, there will be accidents, but there need not be so many. It is the desire and duty of the people in public health to apply their energies and knowledge to the prevention of accidents in the home.

Conference Committee on Structure and Program Meets

AT A MEETING held February 12, 1957, in Chicago, Ill., the Committee on Structure and Program of the Home Safety Conference of the National Safety Council accepted a statement on structure and operating procedures of the Home Conference.

Among the points brought out in this statement were a definition of the function of the conference, its relationship to the National Safety Council, the scope and policy of the conference, officers, committees, and membership. The Home Safety Conference is limited to 100 representatives of national, state, and local organizations, grouped into main divisions—Health and Medical, Home Building and Equipment, and Community Service (Civic) Groups. A copy of this approved statement is available upon request.

The committee also agreed to establish a Committee on National Organizations as a part of the Home Safety Conference and approved procedures to survey national organizations for possible conference membership. They set up procedures for uniform liaison representation to and from all National Safety Council conferences and agreed to invite the Industrial Safety Conference's Off-the-Job Committee members to sit in on the Home Conference's annual meeting as guests. An ad hoc membership committee was also established.

The committee approved pilot studies of a proposed leadership training program.

In order to encourage the establishment of home safety committees in local safety organizations, the committee passed a resolution for the consideration of the Conference of Local Safety Organizations which included such points as the establishment of the committee, type of representation, and inclusion of home safety on the program for every local safety conference and emphasized the placing of responsibility for activities and programs on local organizations rather than on the local council itself.

Mrs. Cobia Succeeds Downey in Missouri

MRS. JACQUELINE COBIA has recently been appointed as health educator I with the Missouri Division of Health assigned to work full-time in the field of home safety. She succeeds James Downey who recently resigned to work with the Jefferson City Chamber of Commerce. We welcome Mrs. Cobia to the "home safety family," and pass on her request for suggestions and tips from the "old pros" in home safety. She'll welcome any help you can send her way.

UNATTENDED YOUNGSTERS AND FIRE

In New York City recently, Fire Commissioner Edward F. Cavanagh, Jr., reported that ten children in a period of ten days had been killed by fire—all ten were youngsters who had been left alone and were helpless to escape from their beds and homes. In New Brunswick, Deputy Provincial Fire Marshal E. J. Sturgeon reported nine children victimized within a week's time for the same reason. A grim total of similar fatalities among children everywhere has mounted steadily all winter.

The NFPA Fire Record Department estimates that approximately 1200 children under 14 years of age were killed in dwelling fires last year because they were left alone or in the care of incompetents.

There have been a number of encouraging reports from fire officials in Cedar Falls, Iowa, Greenfield, Massachusetts, Memphis, Tennessee, Province of New Brunswick, West Milwaukee, Wisconsin, and other places, of positive programs that are being undertaken to prevent these tragedies.

If your community is conducting such a program or if you know of an organization sponsoring baby-sitter training classes or other activities designed to safeguard and improve the care of children in the parents' absence, please notify the NFPA Public Relations Department. If possible, give the details on the program—its objectives, people involved, results.

It is hoped that the NFPA will shortly be able to prepare a special kit to guide other communities and organizations wishing to initiate campaigns against leaving children unattended.—*Fire News*, March 1956, No. 452.

BELUE DIRECTOR IN KENTUCKY

H. EARLE BELUE is now director, Division of Accident Prevention, Kentucky Department of Health, Louisville, Ky., succeeding E. D. Pulliam who was supervisor of the Accident Control Section of the department.

Medical Society's Exhibit

(from page 26)

Keep them all under lock and key.
It takes but a second to slip and fall;
Don't turn your back on baby at all."

Was such an exhibit successful? All pamphlets and literature were completely exhausted by the second day of the 4-day Fair, and there was almost no time when the exhibit was not completely surrounded by spectators. The physicians who participated on the first and second day were so gratified by the public response that they doubled their time so that the booth was never unmanned during the last two days.

The society even plans for a much larger exhibit on a home safety subject in the immediate future. The general attitude of the society's members was that if only one accident was averted, they had performed their service well.

FOR DISTRIBUTION

Is Your *Home Fall Proof?* is a 4-page checklist on the prevention of falls in or around the home. This is 3¾ by 8½ inches, printed in green on yellow stock, published by the National Safety Council, Stock No. 599.23. Prices: 1-9 copies, $.15 each; 10-99, $.06; 100-999, $.035; 1,000-4,999, $.029; 5,000-9,999, $.025; 10,000-19,999, $.022; 20,000 or more, $.02. These prices are subject to 10 percent discount to National Safety Council members.

Prevent Falls on Steps is a 4-page leaflet which illustrates photographically ways to prevent falls. This is 5½ by 8½ inches, black and white, published by the National Safety Council, Stock No. 699.31. Prices: 1-9 copies, $.07 each; 10-99, $.033; 100 or more, $.02. These prices are subject to 10 percent discount to National Safety Council members.

Safety for Amateur Electricians, Safety Education Data Sheet No. 78, prepared by Prof. Ira H. Johnson, head of the Industrial Arts Department, Mankato State Teachers College, Mankato, Minn., contains information on general safety precautions concerning electricity plus special safety precautions in the replacing of a blown fuse, defective switch, or electric outlet, repairing of appliances, etc. This is 7 by 10 inches, black and white, illustrated, published by the National Safety Council, Stock No. 429.04-78. Prices: 1-9 copies, $.10; 10-99, $.058; 100 or more, $.046. These prices are subject to 10 percent discount to National Safety Council members.

Your Clothing Can Burn! is a 4-page leaflet which lists the most frequent causes of fires to children and elderly persons and gives suggestions for the prevention of such fires. The leaflet is 3¾ by 8½ inches, 2-color, illustrated, prepared by the Committee on Wearing Apparel of the National Fire Protection Association, 60 Batterymarch Street, Boston 10, Mass.

The following materials for Spring Cleanup Campaigns are available from the National Fire Protection Association:

Emergency Phone Numbers, a card, $5 per 100, $35 per 1,000.

Help Sparky Clean-up, a folder, $2 per 100, $17.50 per 1,000.

Sparky's Official Home Fire Inspection Blank, a checklist, $1 per 100, $7.50 per 1,000.

Time for Clean-up, a poster, black and white, 8½ by 11 inches, suitable for coloring by youngsters, $.75 per 100, $6.00 per 1,000.

Time for Clean-up, a poster, 2-color, 11 by 17 inches, $2.50 per 100, $20 per 1,000.

Time for Clean-up, a sticker, $1.25 per 100, $10 per 1,000.

For further information write the NFPA, 60 Batterymarch Street, Boston 10, Mass.

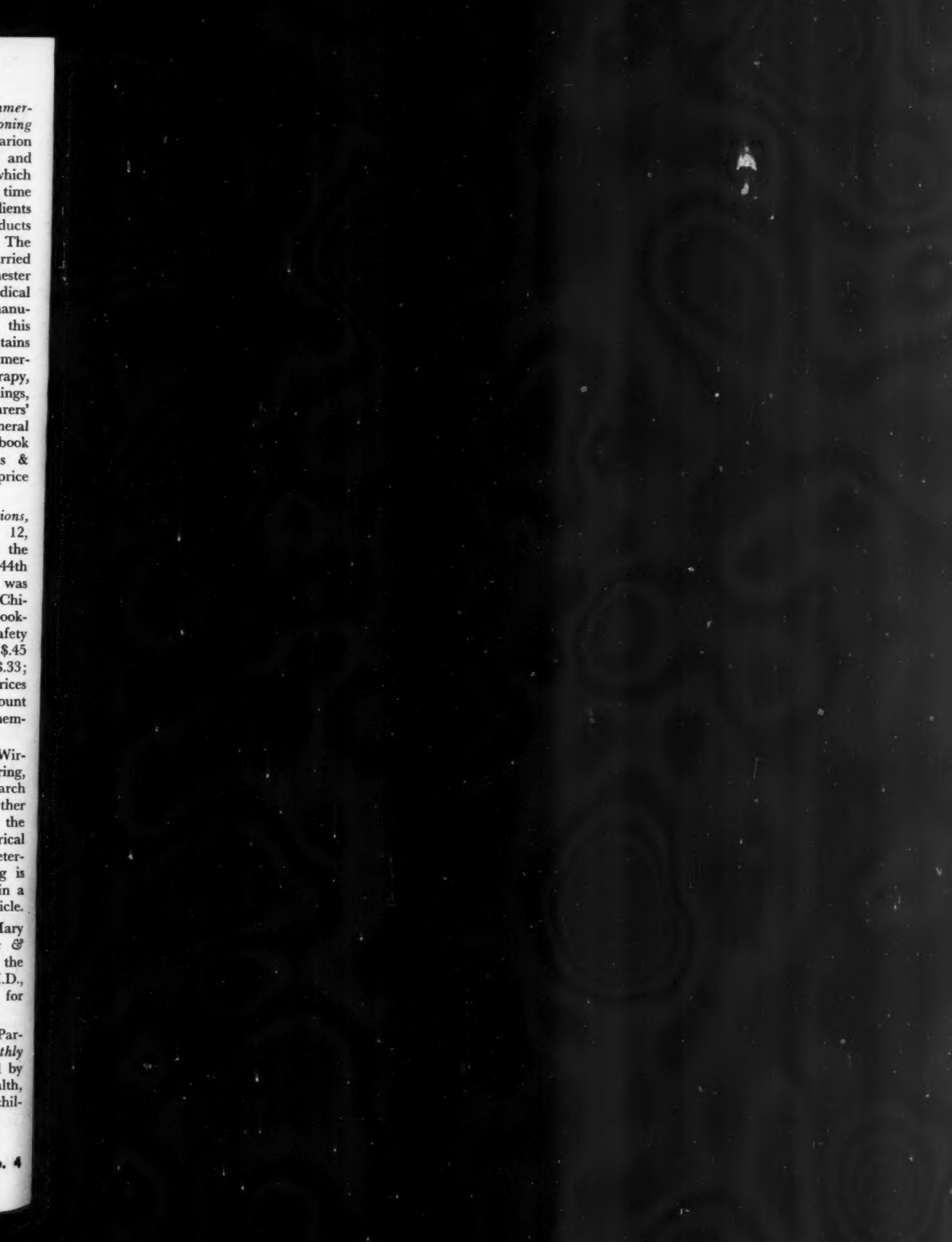
REFERENCE MATERIALS

"The Children's Center, Childhood's No. 1 Enemy," by L. Emmett Holt, Jr., M.D., *Good Housekeeping,* March 1957, enumerates the hazards of accidents to children and urges parents to protect their children while educating them to be careful themselves.

Clinical Toxicology of Commercial Products—Acute Poisoning (Home and Farm), by Mrs. Marion Gleason, Dr. Robert Gosselin, and Prof. Harold Hodge is a book which makes available for the first time information on the toxic ingredients of over 15,000 trade name products in the home and on the farm. The authors directed a project carried on at the University of Rochester and were assisted by senior medical students, civic groups, and manufacturers, among others, on this book's preparation. It also contains information on first aid and emergency treatment, supportive therapy, therapeutics for specific poisonings, followup treatment, manufacturers' names and addresses, and general formulations. This 1,160-page book is published by the Williams & Wilkins Co., Baltimore, Md., price $16.

Home Safety, 1956 Transactions, Current Safety Topics—Vol. 12, contains speeches presented at the Home Safety Sessions of the 44th National Safety Congress which was held October 22-26, 1956, in Chicago, Ill. This is a 48-page booklet published by the National Safety Council. Prices: 1-9 copies, $.45 each; 10-99, $.37; 100-999, $.33; 1,000 or more, $.33. These prices are subject to 10 percent discount to National Safety Council members.

"How to Know When Your Wiring's Wrong," by Robert Hering, *Better Homes & Gardens,* March 1957, discusses how to tell whether there is insufficient wiring for the load and tells how an electrical contractor checks a house to determine whether additional wiring is necessary. Modernizing wiring in a house is also included in this article.

"Playing with Fire," by Mary Margaret Kern, *Better Homes & Gardens,* March 1957, expounds the theory of Harry F. Dietrich, M.D., of protection and education for children in teaching fire safety.

" 'Poisons' Pose Problems for Parents and Children," the *Monthly Bulletin,* March 1957, published by the Indiana State Board of Health, urges parents to protect their children from household poisons.